

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
THIRD REGION**

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BENEDICTINE HOSPITAL
Employer**

and

Case 3-RC-11841

**NEW YORK STATE NURSES ASSOCIATION
Petitioner**

DECISION AND DIRECTION OF ELECTION

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before a hearing officer of the National Labor Relations Board, hereinafter referred to as the Board.

Pursuant to Section 3(b) of the Act, the Board has delegated its authority in this proceeding to the undersigned.

Upon the entire record in this proceeding, I find:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are hereby affirmed.
2. The parties stipulated that Benedictine Hospital, herein referred to as the Employer, with an office and principal place of business located in Kingston, New York, is engaged in the operation of an acute-care medical facility. Annually, in conducting its business operations, the Employer derives gross revenues in excess of \$50,000, and purchases good and services valued in excess of \$50,000 directly from points located outside the State of New York. Based on the parties' stipulation and the record as a whole, I find that the Employer is engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act and that it will effectuate the purposes of the Act to assert jurisdiction herein.
3. The parties stipulated, and I find, that New York State Nurses Association (herein referred to as the Petitioner) is a labor organization within the meaning of Section 2(5) of the Act.
4. The parties stipulated that there is no collective-bargaining agreement that would

bar a representation election with respect to the petitioned-for unit herein.

5. A question affecting commerce exists concerning the representation of certain employees of the Employer within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the

Act.

The petition seeks a unit of all full-time, regular part-time and per diem registered nurses

employed by the Employer. 1

The parties stipulated on the record that the appropriate unit should include all full-time,

regular part-time and per diem level I and level II registered nurses; SWAT nurses' discharge

nurses; care coordination nurses; staff educators; admission assessment registered nurses; and

registered nurses on permit.

The parties stipulated that the following classifications are supervisory, and should be

excluded pursuant to Section 2(11) of the Act from any bargaining unit found appropriate: chief

nursing officer; program director of the rehabilitation unit; the director of surgical services,

administrative director of patient care services, manager of infusion therapy, director of care

1 The parties stipulated that per diem nurses that work an average of four hours a week should be included in the bargaining unit.

2 The record does not disclose what the acronym SWAT stands for.

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Coordinators, denial management coordinator, infection control coordinator, quality assurance

improvement (QAI) coordinator, risk management coordinator, vice-president of patient care

services; nurse manager, administrative director, clinical coordinator, and nursing supervisor.'

At the hearing, the Employer contended that the petitioned-for unit is inappropriate

because it is premature based on imminent and substantial changes to the bargaining unit and

because certain registered nurses in the petitioned-for unit will be employed by a joint employer,

Nistel, Inc. (Nistel), that has not been a party to this proceeding. In its post-hearing brief, the

Employer argues that the petitioned-for unit is inappropriate because it does not include nonsupervisory

nurses employed by The Kingston Hospital (Kingston), which is undergoing a

consolidation of services with the Employer, and because the petitioned-for unit does not include employees of a third-party employer, Nistel, which has not provided express consent to include its employees in the unit. 4

The Employer further contends that there are four categories of RNs not eligible for inclusion in the unit because they are statutory supervisors within the meaning of Section 2(11) of the Act: (1) evening/night charge nurses, herein referred to as titled charge nurses' (2) rotating charge nurses; (3) level III and level IV registered staff nurses; and (4) clinical nurse specialists.

The Petitioner has agreed to proceed to an election in any unit found appropriate. Based on the record herein, I find that the evidence fails to demonstrate that the petition is premature. Contrary to the Employer, I find that the petitioned-for bargaining unit is not

3 The parties stipulated to the exclusion those individuals who act as nursing supervisors 100 percent of their work time.

4 The Employer does not contend that the Employer and Kingston are joint employers of the employees at issue herein.

5 Although the actual title for these individuals is evening/night charge nurse, in the record the parties referred to the employees in this classification as titled charge nurses.

3 inappropriate based on imminent, substantial changes to the bargaining unit. I further find no

-i('I, evidence that, at the time of the hearing, any employees in the petitioned-for bargaining unit are employed by Nistel, alleged to be the joint employer herein, nor do I find any evidence that

Nistel is a joint employer of any employees in the petitioned-for unit.

Regarding titled charge nurses, I find that the record demonstrates that individuals

employed in this classification are statutory supervisors within the meaning of Section 2(11) of the Act, and should be excluded from the bargaining unit found appropriate herein.

Regarding the supervisory status of rotating charge nurses, level III and level IV registered nurses, and clinical nurse specialists, I find that the Employer has failed to meet its

burden of demonstrating that individuals working in these classifications exercise any indicia of supervisory authority as set forth in Section 2(11) of the Act.

FACTS

Background

The Employer is a faith-based hospital located in Kingston, New York. The Employer reports to a board of directors and its sponsors, the Benedictine Sisters of Elizabeth, New Jersey, a Catholic religious order. The Employer's overall mission is set by its board of directors, and the executive staff implements policies and procedures in accordance with the mission as approved by the board and the Benedictine sisters. The main campus is located at 105 Mary's Avenue in Kingston, New York. The Employer has an off-site location at 25 Field Court in Kingston where it houses its adult partial program. The Employer has been in operation for 107 years, and is one of two hospitals located in Kingston, New York. The other hospital, Kingston, has its main campus at 396 Broadway in Kingston, New York, and is located less than a half mile from the Employer's main campus.

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Prior to 2005, the two hospitals functioned independently, with each offering similar services and utilizing some joint medical staff. For the most part, the hospitals were competitors, and there was little to no cooperation in the provision of medical services.

The Consolidation Issue

In 2005, the two hospitals commenced a collaborative effort toward the creation of shared services, employees and governance of the two facilities. The impetus behind this collaboration was the expectation that an alignment between the two entities would be mandated by the Berger Commission." As anticipated, in December 2006, the Berger Commission issued its report recommending that the Employer and Kingston join forces under a single governance structure and reduce the duplication of services. The report further stated that if the parties failed to develop a plan for consolidating the services of the two hospitals by December 31, 2007, the

Berger Commission could grant to the Commissioner of Health the power to close one of the hospitals and expand the surviving hospital to accommodate the health care needs of the region. On December 29, 2006, the chairs of both hospitals signed a memorandum of agreement setting forth the negotiated plan for the alignment of the two hospitals under a parent corporation that would be the sole corporate member of Kingston and Benedictine. Under the terms of the agreement, both hospitals will continue to operate as separate and distinct corporations, with each retaining its own board of directors and corporate mission. Health Alliance Planning, herein called HAP, was formed in September 2007 as the sole corporate member of both hospitals to commence and oversee the consolidation process. Its two executive vice-presidents are Michael Kaminski, president and chief executive officer of

6 The Berger Commission is a New York State commission created to ensure that the regional and local supply of hospital and nursing home facilities is best configured to appropriately respond to community needs for high-quality, affordable and accessible care.

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Kingston, and Thomas Dee, the Employer's president and chief executive officer. HAP is a passive parent corporation with limited powers. At some point in the consolidation process, explained in more detail below, HAP will cease to exist and another entity, Health Alliance, will become the active parent. Health Alliance's chief executive officer will oversee both hospitals, with each hospital retaining separate administrators who will report to Health Alliance's chief executive officer.

As part of the consolidation process, the Employer and Kingston contracted with consultants to develop financial and physical models that would allow the hospitals to consolidate services while continuing to operate successfully as independent entities. The boards of both hospitals decided on a shared revenue plan, which is based on the realignment of revenues at the end of each year, and a two-campus model, calling for the consolidation of most

departments in both hospitals to be located at one campus or the other. Kingston applied for, and has been awarded, 47.6 million dollars in Health Efficiency and Affordability Legislation (HEAL) funds from DOH in order to complete the renovations necessary to effect the two campus plan." Renovations must be completed by December 31, 2009 in order to secure the HEAL funds.

The primary impediment to consolidating the services of the two hospitals is that the

Employer, as a Catholic hospital, cannot provide, or be involved in the provision of, abortion and

voluntary sterilization services, procedures that are currently being performed at Kingston and

which must continue to be available in the community pursuant to the Berger Report. The

Employer's mission also prevents alignment or cooperation with entities that perform these

services, or that employ personnel that perform these services. The parties ultimately decided

7 Only one entity can apply for HEAL funds and the parties agreed, based on the toss of a coin, that Kingston would make the application.

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that a third-party entity that performs the services at issue and employs the personnel involved in

the provision of those services, would accommodate both the mission of the Employer and the

mandate of the Berger Commission. Accordingly, the parties developed a plan for the creation

of Foxhall Ambulatory Surgery Corporation, herein called Foxhall.

Foxhall will be an ambulatory surgery center that will service the Kingston, New York

medical population. It is scheduled to become operational in or around February 2009.⁸ Its two

corporate members are the Kingston Hospital Foundation and the Foxhall Ambulatory Surgery

Foundation. It will be located approximately six feet from Kingston in what is presently the

Kingston parking lot, and it will provide services in the areas of ophthalmology, podiatry, ear, nose

and throat, and gynecological procedures as well as abortions and sterilizations. It is

estimated that approximately 1200 outpatient procedures will be performed there annually, with

approximately 200 of those procedures abortions and sterilizations. The Employer is not involved with the development of Foxhall. Rather, Kingston is overseeing the construction and development of that facility. Construction on Foxhall is in the bidding process," Because Foxhall cannot be staffed with personnel that are employed by either the Employer or Kingston, Foxhall entered into an agreement with Nistel, an administrative service organization, on July 17, 2008. Under that agreement, Nistel will, inter alia, provide human resource services to Foxhall, including credentialing of prospective staff, recommendations for hiring, fixing compensation, discharging and directing the activities of personnel, and assisting in the adoption and enforcement of policies regarding the operation of Foxhall. Nistel will also

8 Upon the completion of Foxhall, HAP will become inactive and Health Alliance will become the active parent of all three entities, with the responsibilities of determining the finances of all three facilities, approving budgets, capital leases, capital purchases, property purchases and sales, program changes and consolidation of programs.

9 The record discloses that the commencement of construction on Foxhall was delayed because the initial bids came in over-budget.

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provide various billing, budget and administrative functions for Foxhall. Nistel and Foxhall are currently negotiating the terms of the employee-leasing agreement. Foxhall will, at its inception, most likely be open one day a week, and will probably only

operate two to three days at its peak. Nistel will hire some of both the Employer's and

Kingston's registered nurses (RNs) at their current salary and benefit plan, and will perform

human resource functions in accordance with the requirements of the individual hospitals. Jane

Lucente, director of surgical services, will supervise the RNs hired by Nistel.

Lucente, currently

employed by Kingston, will become employed by Nistel and will be leased back to Kingston and the Employer.

Because Foxhall alone will be unable to provide sufficient employment opportunities to

its staff, RNs hired by Nistel will rotate to all three facilities (the Employer, Kingston and Foxhall), and will participate in other procedures, such as abdominal and arthroscopic surgeries, that will be offered at the hospitals but not at Foxhall. The Employer provided conflicting evidence as to how many nurses will be employed by Foxhall, with different witnesses testifying that Nistel will employ anywhere from 45 to 100 RNs who are qualified to participate in surgical procedures offered at all three facilities. After hiring both the Employer's and Kingston's nurses, Nistel will be responsible for hiring any new nurses based on each hospital's respective vacancies. Although it is clear that all RNs transferred to Nistel's payroll from the Employer and Kingston will work under the terms and conditions of their home hospitals, the record is unclear as to which entity will set the terms and conditions of employment of the new hires. The date that Nistel will hire nurses remains uncertain, and depends on the progression of construction for Foxhall and negotiations regarding the staffing agreement. Kingston's president Kaminski testified that RNs could move to Nistel's

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payroll as early as August or September, 2008. The record does not disclose whether Nistel will hire a full complement of RNs at the onset, or whether it will hire minimal staff initially and increase staffing as services continue to be consolidated. Several administrative and managerial functions have been consolidated. The financial divisions of both hospitals are currently located at one site, and credentialing of staff has been consolidated under a single department since April 1, 2008. The senior vice-president of finance and the chief financial officer for HAP have been jointly employed by the Employer and Kingston since February 2008, and the Employer's vice-president of finance and its chief information officer are both jointly employed by Kingston. The hospitals have also consolidated certain patient care management services. Margo

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McGilvrey, chief nursing officer for both hospitals, is currently employed by HAP, and is responsible for the day-to-day nursing operations at Kingston. McGilvrey reports to Thomas

Dee and Michael Kaminski. Kathy Lunney, acting vice-president of patient care services for the

Employer, reports to McGilvrey, and is responsible for the day-to-day nursing operations for the

Employer. Jane Lucente, director of surgical services for Kingston, reports to McGilvrey, as

does the director of the two medical-surgical units at Kingston. The physical and occupational

therapy department, the physical medicine and rehabilitation department, the sleep lab and the

cardiology department at Kingston all report to McGilvrey.

Greg Howard, Kingston's human resource manager, has been working with HAP since

September 2007 to bring together the human resource departments of the Employer and

Kingston. Individuals from Kingston and the Employer have been meeting on a biweekly basis

to discuss various human-resource issues affecting the alliance, and have been sharing

information such as benefit and wage structures, employee handbooks, and policies. The two

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hospitals have begun posting job openings at both hospitals and have developed a policy that

gives first preference to the applicant from the home hospital, with next preference to applicants

from the other hospital. The committee is also involved in trying to find a benefit broker to

service the benefits of all facilities under HAP. Although the committee has been asked to put

together a model of what consolidated human resource departments would look like, the human

resource departments are currently not consolidated. The record does not disclose whether

consolidation of the human resource departments will, in fact, occur and if so, when such

consolidation would take effect.

The Employer's RNs have different wages and benefits than the RNs employed by

Kingston. McGilvrey testified that the Employer's and Kingston's RNs earn different pay

differentials for charge, evenings, nights, and on call duties.

As of the date of the hearing, the Employer maintains its own personnel records kept at the Employer's facility, processes its own payroll, and provides unemployment insurance,

malpractice insurance and workers compensation insurance only to its own employees. The Employer's RNs are scheduled by the Employer in accordance with its scheduling policy, and are subject only to the Employer's on-call policy. RNs at both hospitals are required to meet certain state education and licensure requirements. Some nurses have additional certifications and training, depending on the departments in which they work. Pediatric life support certification and advanced cardiac life support certification are required in certain departments at both the Employer's facility and Kingston. Stroke certification is required by state law for any RN caring for a stroke patient.

The record demonstrates that the education departments at both hospitals have been working together since August 2007 to address mandatory education needs and have jointly offered some

10 RN certification classes at Kingston's education building. Although the Employer's RNs have attended certification classes at Kingston in past years for a fee, these classes are now available to the Employer's RNs for free.

According to chief nursing officer McGilvrey, one of Kingston's three educators is working at the Employer's campus part-time as part of a current project to combine mandatory education, and certain of Kingston's case managers (a position known as care coordinator on the

Employer's campus) provide some services at the Employer's campus. In addition, the parties have begun developing plans for Kingston staff to review the Employer's documentation and to

become involved in the Employer's educational offerings.

Certain patient care services have been consolidated. The hospitals have consolidated

wound care, cardiac catheter services, and infection control services. As of July 1, 2008, both

hospitals have in-patient wound care services and all outpatient wound care is located at the

Kingston campus. Barbara Petersen is a per diem registered nurse highly skilled in ostomies.

Petersen is employed by the Employer and she performs services for both the Employer's and

Kingston's patients. Kingston reimburses the Employer for services performed there by

Petersen.¹⁰ RN Erin O'Leary is employed by Kingston and is responsible for inpatient wound

care. O'Leary recently performed Petersen's duties at the Employer's campus when Petersen

was on vacation. Both Petersen and O'Leary are supervised by Sandy Huran, vice-president of

ancillary services at Kingston.

The cardiac catheter department has shared resources for approximately five years, with

staff going back and forth between hospitals. As of July 7, 2008, all cardiac catheter outpatient

¹⁰ Although it appears that Petersen may have performed some functions for Kingston before the alignment began, and that she

was paid directly by Kingston. McGilvrey testified that since HAP's formation, the reimbursement for Petersen's services is

between hospitals and not directly to her. The record does not specify the manner in which reimbursements are handled.

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services for both hospitals will be located at Kingston, with each hospital offering inpatient

services. After consolidation, all cardiac catheter inpatient services will be located at Kingston.

Several months ago, the hospitals reached an agreement whereby the coordinator for

infection control at the Employer's campus and an RN employed by Kingston will coordinate to

provide services for both hospitals. RN Jim Thompson is currently the coordinator for infection

control at the Employer's hospital, and is working on both campuses. Thompson is employed by

the Employer, with Kingston paying half of his salary. ¹¹

Consolidation of the physical medicine and rehabilitation departments of the two hospitals was initially scheduled for July 2008, but was delayed to August 4, 2008, because the

hospitals are awaiting Medicare approval of the consolidation. Eight of the Employer's RNs

currently employed in the physical medicine and rehabilitation department will relocate to the

fourth floor of the Kingston campus, and will work side-by-side with Kingston RNs for

approximately ninety days, while renovation begins at the Employer's campus. Ultimately, physical medicine and rehabilitation staff from both Kingston and the Employer will be located on the third floor of the Employer's facility. The hospitals anticipate a total physical medicine and rehabilitation nursing staff of approximately 14 or 15 RNs after the consolidation, all working in the Employer's facility under one department director who has not yet been selected. There are similar scenarios planned for the consolidation of other departments at each hospital, with various departments temporarily housed in one campus while renovations are completed in other areas of the hospital or on the other campus. The objective of the alignment process is to consolidate 11 to 15 maternity beds at Kingston; consolidate 20 rehabilitation beds at the Employer's campus; shift 20 to 25 substance abuse or mental health beds to the 11 The Kingston position is currently vacant. Once the slot is filled, the RN employed in that position will be employed by Kingston and his/her salary will be shared by the Employer.

12 Employer's campus; increase critical care and medical/surgical beds from 115 to 139 beds at Kingston; and reduce critical care and medical-surgical beds from 103 to 66 beds at the Employer's campus. Central to the consolidation effort is the addition of emergency capacity at Kingston, and additional medical/surgical capacity at Kingston. The Employer's nurses will be working side-by-side with Kingston's nurses in consolidated departments under a common department director. Maternity services will be offered at both hospitals until Foxhall is completed. At that time, all maternity services will be housed at Kingston. The record does not disclose the date renovations will begin, but it appears that the first construction is scheduled to begin shortly. RNs are required to swipe in and out on time clocks. As part of the temporary relocation of the physical medicine and rehabilitation department, the Employer is moving one of its own

time clocks to the physical medicine and rehabilitation unit at Kingston. The Employer's employees working at the Kingston campus will be required to swipe in and out on the Employer's time clocks located at that facility. In furtherance of the upcoming consolidations, the Employer is in the process of purchasing additional time clocks to be located at Kingston, at a cost of \$2,500 to \$3,000 each. A minimum of two of the Employer's time clocks will be located at Kingston, and a minimum of two Kingston time clocks will be located at the Employer's campus. While the Employer provided some evidence that the two hospitals intend to integrate their payroll systems, the record reveals no evidence that there is currently any concrete plan to do so, or when such integration may occur. Managers in consolidated departments at each facility have been instructed to follow the employment policy of the employee's home facility. For instance, if an RN, employed by the

13

Employer but located at Kingston in a consolidated department, has an issue with attendance, the manager is instructed to follow the Employer's absentee policy. The hiring method selected for the consolidated departments is the "open field" method, in which all positions in the consolidated departments are made available to all individuals employed in related departments. Where no job is available for an existing employee as a result of a consolidation, human resources will assist in trying to find the individual a job in their home facility and, if none exists, another facility within Health Alliance. The individuals selected to work in the consolidated departments will continue to be employed by their home hospitals. Likewise, department directors will be employed by their home hospitals, with their salaries shared by two entities.

Disputed Work (RN Classifications)

The Employer classifies its staff RNs into four levels: levels I through IV. The record demonstrates that nurses move through the levels via a clinical advancement program. New RNs

begin at level I and advance to level II based on experience and satisfactory completion of the probationary period. Level II RNs must go through an application process to move to level III, and must complete certain educational and performance requirements, maintain membership in a professional health care organization, and be active in a unit or hospital-wide committee, project or activity. To advance to level IV, level III RNs must meet level III standards, chair or co-chair a council, satisfy additional educational and experience requirements; and meet certain mentoring requirements. Approximately 74 of the Employer's 272 RNs are levels III and IV.

The Employer claims that its three evening/night charge nurses, and an unspecified number of level III and IV RNs in various departments who rotate as charge nurses, are supervisors within the meaning of Section 2(11) of the Act because they make assignments,

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effectively recommend evaluations and discipline, direct the work of employees, and engage in other supervisory duties.

Concerning the manner in which RNs are scheduled, the record demonstrates that unit

schedules are prepared and maintained by Evelyn Graziano, the staffing coordinator for the

Employer. She prepares a six-week schedule for each unit based on an average number of staff

needed for each shift and the availability of the staff. Staffing may then adjusted be up or down

on a daily basis on each unit based on information entered into a computer program by RNs for

every patient on the inpatient units. This acuity-based program, called WIN PFS, calculates the

number of RNs, LPNs, and ancillary staff needed on each unit for the upcoming shift based on

the acuity levels, or medical needs, of the patients. Patients with high acuities require more

attention and potentially more nursing staff. For example, on surgical unit 3

Spellman, normal

staffing guidelines for the day shift are four to five patients per nurse. However, if there are

numerous patients with high acuities, the WIN PFS printout might require additional nursing or

ancillary staff on the next shift, and the staffing level would be adjusted accordingly.

Most nurse managers and clinical coordinators work a day-shift schedule, Monday

through Friday, and oversee their respective units when they are at the hospital. V In addition,

various individuals who rotate in the position of nursing supervisor are on duty evenings and

weekends. Nursing supervisors are the highest ranking individuals in the hospital when they on

duty. Nursing supervisors do not take a patient load; rather, they oversee patient care on all

units. The nursing supervisors make rounds at least once to each floor during each shift, and are

always available by phone, beeper and page. The nursing supervisors have the keys to the

12 The nurse manager and/or clinical coordinator of every unit is always on call.

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mental health units and the staffing book detailing all staff working on all units whenever they

are on duty.

The nursing supervisors are responsible for ensuring adequate staffing in all units, of the

hospital when on duty, and are ultimately responsible for staffing. In this regard, I note that the

record demonstrates that the nursing supervisors are aware of the staffing levels and staffing

needs of all units while they are on duty. Staff calling off from work is required to call the

nursing supervisor, and charge nurses are required to advise the nursing supervisors of any

changes in staff on the unit. If a unit is short-staffed, the nursing supervisors make the decision

as to whether to call in additional staff. Likewise, if a unit is overstaffed, the nursing supervisors

decide whether to call staff and tell them not to report to work. Only the nursing supervisors can

float staff from one floor to another when they are on duty. Charge nurses can make requests or

recommendations regarding staffing on their particular unit but, in the event of a disagreement,

the nursing supervisors; decisions prevail.

It is undisputed that the charge nurses report to the nursing supervisor when their respective nurse managers and clinical coordinators are not present. The record demonstrates

that charge nurses have some ability to adjust staffing within the unit. For instance, if the unit is short-staffed or busier than anticipated, the charge nurse can ask staff to stay over or come in early. Charge nurses can make adjustments to staffing on upcoming shifts to accommodate an employee who may have worked a double shift, and there is some evidence that charge nurses can call employees for coverage when other employees call in to be excused from work. However, all staffing changes operate under the Employer's "no mandation" policy, meaning that no employee can be required to work anything other than his/her regularly scheduled shift.

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Thus, the record demonstrates that charge nurses have no ability to require employees to come in early, work overtime, leave early, or report to work on a scheduled day off. Charge nurses have a standing order to allow staff to work overtime on a voluntary basis for purposes of patient coverage. Charge nurses can let staff leave early, but only in cases of a family emergency. It is the hospital policy to send employees who request to leave early because of illness to the emergency room, and charge nurses are authorized to carry out this policy. Likewise, pursuant to hospital policy, charge nurses can allow staff to leave early if the unit is overstaffed. As noted above, the charge nurse is required to report all changes in unit staffing to the nursing supervisor.

Evening/Night Charge Nurses (Titled Charge Nurses)

The Employer claims that the three titled charge nurses, Rosella Curry, Brittany Jones

and Jennifer Tatar are statutory supervisors, and should not be included in the bargaining unit

found appropriate herein.^f The record demonstrates that these three individuals hold the title

evening/night charge nurse." This classification has its own written job description and

performance appraisal, which contains a category for supervision of the clinical coordination of

the unit. All other staff RNs, including levels I through IV RNs, and RNs that rotate as charge

nurses, fall under the job description and performance appraisal for staff nurse, which contains

no category for supervision of clinical coordination of the unit. There is no evidence in the record that the rotating charge nurses are evaluated based on the performance of charge duties. I

note that the record contains no evidence that either the titled or the rotating charge nurses suffer

13 The Employer provided a wage range for individuals employed as titled charge nurses. The Petitioner objected to this testimony based on the Employer's refusal to provide payroll documents as requested in the Petitioner's subpoenas. Although I do not specifically reject the testimony regarding the wage ranges of titled charge nurses, I have not relied on the testimony herein, because it is of no significance in the absence of comparative evidence regarding the wages of staff RNs.

14 Consistent with the terminology in the record, the evening/night charge nurses are herein referred to as titled charge nurses.

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the prospect of any adverse consequences based on the performance of any staff members that they purportedly direct on the unit, or that any charge nurse has been disciplined for a staff member's failure to perform a job duty. IS

Irene Jimenez is the nurse manager on 4 Spellman, a 31-bed medical-surgical unit.

Jimenez testified both about Rosella Curry's duties as evening charge nurse, and the duties of rotating charge nurses on 4 Spellman. Curry works from 3:00 p.m. to 11:00 p.m. five days a

week, including rotating weekends. According to Jimenez, titled charge nurse Curry is the highest ranking official on the unit when Jimenez and the clinical coordinator are not there. The

record demonstrates that Curry sometimes has a patient load, and sometimes does not, but that

she generally has a lighter patient assignment than the staff RNs. The record contains no

evidence why Curry's patient load may vary, and why she sometimes has patients and sometimes

does not. 16

According to nurse manager Jimenez, charge nurses perform nursing duties, make

assignments twice during their shift to certified nursing assistants (CNAs), handles issues on the

unit regarding patients and families, as well as problems nurses cannot solve on their own;

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coordinate with the nursing supervisor; and are the "go to" people for anything needed on their

units. The charge nurses are responsible for maintaining the daily logs on their shift and for

checking supplies.

Nurse manager Jimenez testified that one of the primary responsibilities of the charge

nurses is to oversee staffing on the unit. Staffing in 4 Spellman is based on a ratio of between 5

15 In so finding, I note that the record does not contain any completed performance evaluations for either the titled or

rotating charge nurses demonstrating that they are actually ranked on the supervision factor or on the performance of

their charge duties. I further note that the Employer provided no evidence that titled charge nurses or the rotating

charge nurses receive any benefit or suffer any detriment based on the

Employer's evaluation of the performance of

their charge duties.

16 Staff nurse Jennifer Kaiser testified that on one occasion, Curry did not have a patient load because she was filling

in for the unit coordinator.

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and 6 patients per nurse on the day and evening shifts; and between 6 and 10 patients per nurse

on the night shift, with some variation depending on the acuity of the patients.

According to

Jimenez, the charge nurses make RN assignments based on the number of patients, and the

illness of the patient. For example, a new nurse would not be assigned as many patients as a

more experienced nurse, or would not be assigned a patient that requires expert care. According

to Jimenez, some RNs are better at certain duties, or have more training or interest in certain

areas, such as wound care and respiratory issues, and this is common knowledge on the unit.

Nursing skills are generally not considered in patient assignment on 4 Spellman, as the RNs are

trained to take care of most situations.

Charge nurses assign the bed for patient admissions coming onto the floor, and assign an

RN to take the admission. Admissions are normally assigned by patient load, meaning that the

RN with the fewest patients will ordinarily receive the next admission. However, if an RN has a lighter load but has a patient who is having difficulties, the charge nurse assigns the admission to another RN. Some RNs cannot take patients in the isolation rooms because of health reasons.

The record contains conflicting evidence about the manner in which the two to four

CNAs on 4 Spellman are assigned to patients. According to nurse manager Jimenez, titled

charge nurse Curry assigns the CNAs to the patients and to the RNs. However, some RNs

testified that CNAs generally split the unit geographically, i.e., in halves, thirds, or quarters

depending on the number of CNAs, with each CNA responsible for the patients in his/her

geographic area."

CNAs have basic duties such as feeding and bathing patients, answering call bells, taking

17 LPNs are not permitted to handle admissions but may be assigned the patient after the patient has been processed

by the RN.

18 The record does not disclose how this geographic division is determined.

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finger sticks, and checking vital signs. Nurse manager Jimenez testified that the charge nurse

and RNs can delegate other duties to the CNAs as needed, but she provided no specific examples

of the manner in which they direct the work of CNAs. Jimenez testified that CNAs and nurses

check with the charge nurse regarding their lunch times, in order to ensure adequate coverage on

the unit. RNs have preferred lunch times that may vary based on how busy the unit is.

Nurse manager Jimenez testified that the charge nurse is informed about all patient issues

on the floor. The charge nurse makes sure everything that is needed for the patient's care is

available, offers help to the staff RN, and answers questions from nurses and doctors. If an RN

cannot leave her patient to speak to the physician, or if the doctor has problems with the manner

in which the attending RN is caring for the patient, the physician talks to the charge nurse.

Nurse manager Jimenez testified that if a nurse or CNA is not performing their duties or

is taking too long for breaks, the charge nurse can speak to them about the issue. Jimenez could recall no specific example of when a charge nurse has talked to CNA about such matters, but recalls an incident with an unidentified RN regarding patient safety. Although Jimenez testified that she asks the charge nurses to document the verbal warning, the record demonstrates that Jimenez investigates issues of staff misconduct and she makes the determination regarding whether to place a note in the employees' unit files. Nurse manager Jimenez testified that she discusses the job performance of RNs with the charge nurses. Although charge nurses do not directly evaluate RNs, Jimenez stated that the charge nurses have input and she asks them questions about things that she does not directly observe because she does not work the same shift as some of the RNs that she evaluates. The two remaining titled charge nurses, Jennifer Tatar and Brittany Jones, work on .J Sister Mary Charles (3 SMC), the progressive care, or telemetry unit. The unit handles 20 cardiopulmonary patients and ventilated patients, and is the designated stroke unit. Including nurse manager Drake and the clinical coordinator, both of whom work day shifts Monday through Friday, there are 29 RNs on the unit. Nurse manager Drake testified about titled charge nurse duties on 3 SMC. Tatar works from 5:00 p.m. to 5:00 a.m. Sunday, Monday and Tuesday, and Jones works the same shift on Wednesday, Thursday and Friday.¹⁹ Neither Tatar nor Jones normally carries a patient load, but they may take patients when necessary to fill in as needed. ., On 3 SMC, there is a dry-erase board that lists the nurses on duty for that shift and the rooms they are covering. The daily assignment sheet is a list of all nurses on duty and the patients for whom each nurse is responsible. The dry-erase board and daily assignment sheet are updated throughout the shift as patients are admitted and discharged. The clinical activity lists are printed out by individual nurses, and they list each patient assigned to that nurse. Drake

testified that the charge nurses make changes to the daily assignment sheet and print out the clinical activity lists for the next shift. The record demonstrates that any RN can make changes

(,~ to the clinical activity list.

Nurse manager Drake testified that the charge nurses on 3 SMC are responsible for the

oversight and functioning of the floor with nursing and ancillary staff. One of the charge nurses'

primary responsibilities is the assignment of patients to nurses. Drake testified that charge

nurses use their judgment to make the assignments to the nurses coming on duty based on their

skill level and knowledge, the patient's condition, and what treatments and procedures will be

needed. Drake testified that nurse assignments are also based on the location of the rooms, to

avoid having nurses spend time traveling between rooms not located near each other.

19 The record does not disclose who, if anyone, covers charge duties on Saturdays.

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Titled charge nurse Tatar prepares the assignment sheets for the 7:00 p.m., 11:00 p.m.,

and 7:00 a.m. shifts. Nurse manager Drake testified that Tatar's experience helps her in making

assignments, and she is familiar with the education level and expertise of nurses coming on duty

because she has precepted many new nurses.f" According to Drake, Tatar makes staffing

assessments based on the education level and expertise of the nurses coming on duty, and the

acuity of the patients currently on the floor. On 3 SMC, some RNs may have let their stroke

certification lapse, and LPNs cannot administer drip medications, and the charge nurses assign

nurses to patients appropriately in light of such circumstances.

Nurse manager Drake testified that if the nursing supervisor contacts the charge nurse

and requests staff for another unit, the charge nurse decides which staff member to send.

Although Drake testified that she has requested staff when she sometimes acts as a nursing

supervisor, she was unable to recall a specific example of when she has done so. Conversely, if

the unit is short, the charge nurses contact the nursing supervisor to see if someone is available in the float pool, or from another floor. Nurse manager Drake testified that the charge nurses decide whether more or less staff is needed. Drake testified that she has instructed the charge nurses regarding situations when they can ask staff to come in when not previously scheduled, or to stay over beyond their assigned shift time. Drake has also instructed charge nurses that they can offer staff members the next day off if they work a double shift. Drake stated that the charge nurses talk to the nursing supervisor about changes in staffing. The record demonstrates that it is standard policy for charge nurses to call staff in for emergencies.

20 The Employer requires that new nurses receive training, or precepting, under a more experienced nurse for a period ranging from 3 to 12 weeks.

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Witness testimony demonstrates that on 3 SMC, two CNAs on the day and evening shift usually split the floor in half, with each taking patients on half the floor. 21 There is only one CNA on the night shift.

Charge nurses assist nurse manager Drake and a clinical coordinator with data collection

pertaining to quality issues, and are responsible for ensuring that things run smoothly on the

floor. Charge nurses also handle issues with family members and doctors.

Although not

specifically a charge duty, Drake testified that titled charge nurses Tatar and Jones have taken

over responsibility for the crash cart, which needs to be checked daily, as well as the accudose

machine, which must be checked weekly. Drake testified that she evaluates the titled charge

nurses annually based on the performance appraisal attached to the job description for

evening/night charge nurse.

Nurse manager Drake testified that titled charge nurse Tatar updates the daily log

statistics, and that she and titled charge nurse Jones assist the unit with data collection for quality

measures. Drake testified that the charge nurses are responsible for auditing their peers,

including the hand washing auditing forms and IV audits. Charge nurses complete an incident report if something happens on their shift, like a medication error. Nurse manager Drake testified that the charge nurses on 3 SMC have the authority to issue discipline, and that there have been verbal, but no written disciplines. According to Drake, titled charge nurse Tatar spoke to a senior nurse about problems with the report, and recently spoke to two evening CNAs who were talking excessively. Tatar advised Drake about both incidents. Drake followed up with the nurse because the problem has continued, but did not talk to the aides because, according to her, Tatar resolved the issue.

21 The record does not disclose how the determination is made as to how CNAs divide the unit.

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Nurse manager Drake testified that she consults with Tatar when preparing the annual reviews of the evening and night shift employees. Drake has not received such input from Jones yet because she is new in the position, but she testified that she intends to consult with both Tatar and Jones for the upcoming appraisals. Drake testified that the charge nurse randomly audits RN patient notes to ensure that documentation reflects what was done on the shift, and that the charge nurse either speaks directly to the RN about documentation problems, or brings the issue to Drake's attention.

Rotating Charge Nurses

Level II, III and IV staff RNs may serve as rotating charge nurses on a voluntary basis.

The record does not disclose how many of the RNs serve as rotating charge nurses. The rotating charge nurses have the same job description and are subject to the same performance evaluation as the staff RNs who do not rotate as charge nurses.

4 *Spellman*: Nurse manager Jimenez' testimony did not distinguish between the charge duties of titled charge nurse Curry, and the charge duties of the rotating charge nurses. Although it appears that other RNs rotate as charge nurses on 4 Spellman, Jimenez testified only about level III RN Kathleen Oldehoff. According to Jimenez, Oldehoff assumes charge duties when

the clinical coordinator is not there, or on the weekends, and that she rotates this position with other nurses. The record does not disclose what percentage of work time Oldehoff is scheduled as charge nurse, or how frequently she rotates as charge nurse. Jimenez stated that Oldehoff makes the assignment for the evening shift. According to Jimenez, Oldehoff assigns nurses and CNAs to patients, assigns beds if there are admissions, and assigns RNs to the admissions. Jimenez testified that Oldehoff makes assignments based on workload, how sick patients are, and the experience of the nurse.

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Jennifer Kaiser is a level III float pool RN and has been employed by the Employer for approximately ten years. Kaiser floats to oncology (4 SMC); medical-surgical (4 Spellman);

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telemetry (3 SMC); surgical (3 Spellman); radiology and the emergency room. Kaiser performed charge duties approximately three years ago, when she was on 4 Spellman. According to Kaiser, she made assignments, checked the crash cart and restraint logs, filled out paperwork, and if she did not have a patient assignment, helped other nurses, wrote doctors' orders on charts, and helped RNs sign off on orders. At the end of the shift, Kaiser put in the patient assignment for nurses on the upcoming shift and printed out the clinical activity list for each nurse. Kaiser testified that she did not consider the acuity of the patients when she did patient assignments, because all nurses on 4 Spellman have the same capabilities. At the time Kaiser performed charge duties on 4 Spellman, there was no clinical coordinator. The record demonstrates that Kaiser floats to 4 Spellman frequently. According to Kaiser, the goal on 4 Spellman is to group nurses by room locations for purposes of efficiency because it is such a large unit. Kaiser stated that isolation rooms are divided equally among nurses, and are assigned based on their proximity to the RN's other patients. Kaiser stated that she has never seen a charge nurse discipline anyone and she has never disciplined an LPN or a CNA. Kaiser testified that on 4 Spellman, approximately one month

ago, she noticed that a CNA was not taking a patient's vital signs as directed by the physician..

Kaiser was not disciplined, nor was the nurse on duty before her.

Kaiser testified that level II nurses Jennifer Delage and Susan Brooks also rotate as

charge nurses. I note that the Employer provided no evidence distinguishing charge duties

performed by Delage and Brooks from the charge duties performed by Oldehoff when in the

charge capacity.

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3 SMC: On 3 SMC, 17 of the 25 staff RNs rotate as charge nurse in the unit. Nurse

manager Drake testified that level III RN Jill Towns is scheduled to rotate as charge nurse at

least once a week and when Drake and Anderson leave the floor for a meeting or at the end of

their shift at 3:00 p.m. When acting as charge nurse, Towns carries a patient load, except when

Drake and Anderson are out of the building. The record does not disclose how often this occurs.

Nurse manager Drake testified that Towns is evaluated pursuant to the evaluation for

staff RNs. Although Drake stated that Towns is evaluated on delegating tasks to coworkers, the

record contains no evidence regarding whether the evaluation of this factor has either a positive

or negative impact on Towns' terms and conditions of employment. Drake testified that she has

observed Towns delegate tasks to a CNA and then follow up with the CNA. The record contains

no evidence that Towns has been disciplined for a CNA's failure to satisfactorily perform a duty.

According to Drake, staff RNs also delegate and follow up on vital signs and finger sticks. The

record is silent as to whether Drake evaluates staff RNs on delegating tasks to coworkers.

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Nurse manager Drake testified that a few days prior to the hearing, rotating charge nurse

James Geskie approved an evening nurse to stay until 3:00 a.m. and asked another nurse to come

in at 5:00 a.m. because the patient load was so heavy and the patients were confused and

combative. According to Drake, a few weeks before that, rotating charge nurse Daria Egan

approved someone to work a double shift and gave that individual part of the next day off without prior approval from Drake, and also called in an RN to cover for another RN who was having a hard time working due to pregnancy. The record does not disclose the regularity or frequency with which Geskie and Egan act in the rotating charge nurse capacity. Level III float pool RN Kaiser testified contrary to the Employer's witnesses regarding the manner in which patient assignments are made on 3 SMC. Kaiser testified that RN Towns is

26

normally the charge nurse when she floats on 3 SMC. According to Kaiser, when the staffing

coordinator calls, any nurse at the desk taking the call can assign a bed to the patient. Kaiser

testified that unit clerks and unit coordinators have also assigned beds.

According to Kaiser, on

3 SMC, clerk Brenda Malone may ask for volunteers to take admissions. Kaiser has volunteered

to take admissions, and has been assigned admissions when she has had fewer patients or was

less overwhelmed than other RNs in the unit.

Kaiser testified that when she works on 3 SMC, her assignment is based on geography,

with the patients assigned to her located near each other. Kaiser stated that all RNs have the

same skills, education and licensure, and that the RNs who act as charge nurses on the units she

works on do not know her education and abilities. Kaiser testified that it is her opinion that the

charge nurse does not consider skills when doing the assignment, because Kaiser is not stroke

certified and she continues to be assigned stroke patients based solely on their location on the unit.

The Employer provided no evidence distinguishing the charge duties of the level II

rotating charge nurses from level III RN Towns' duties when she serves as a rotating charge nurse.

3 Spellman: Sharon Krasher is the director of surgical services for the Employer. She is

responsible for 3 Spellman, the surgical and pediatric floor; ambulatory surgery, which includes

presurgical visits and the post-anesthesia care unit, and the operating room?2
Krasher works

Monday through Friday, from approximately 6:30 a.m. to approximately 5:00 p.m., and is

always on call. Charlene Cohen is the clinical coordinator in 3 Spellman. She works 7:00 a.m. to

3:00 p.m. Monday through Friday, and some overtime from 3:00 p.m. to 7:00 p.m., two or three

22 There are no charge nurses in the ambulatory surgery unit or the operating room.

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days a week. Cohen has charge duties until 7:00 p.m. on the days she works that shift.

The undisputed evidence shows that charge nurses on the night shift carry a full complement of patients, that charge nurses assign admissions to RNs, and that charge nurses

prepare the assignment sheets for the upcoming shift.

Director of surgical services Krasher testified that Kathy Alejongarcia, a level III RNT,

works the 7:00 p.m. to 7:00 a.m. shift on 3 Spellman and rotates as charge nurse approximately

75 percent of the time that she works. Level II RN Glenda Brown, level IV RN Alda Biegel, and

level III RNs Stephen Sommer and Estela Aquino also rotate as charge nurses on 3 Spellman.

The record demonstrates that Sommer acts as charge approximately one weekend day every two

weeks. The record does not disclose how often Brown, Biegel and Aquino perform charge

duties.

Director of surgical services Krasher testified about Alejongarcia's duties as charge

nurse. Day-shift patient care assignments on 3 Spellman are usually drafted the night before.

The nursing supervisor provides the charge nurse with the total number of staff needed for the

7:00 a.m. shift based on the numbers entered into the acuity system from 7:00 p.m. to 11:00 p.m.,

and reviews the staffing for the next shift with the charge nurse. Although

Krasher testified that

it is the responsibility of the charge nurse to make up the daily assignment for the next shift,

another RN can make the assignment if the charge nurse is unable to do so. All RNs have the

experience required to make up the schedule. Krasher testified that if the charge nurse fails to

complete the schedule for the next shift, she would probably not be disciplined for failing to do so.

Director of surgical services Krasher testified that charge nurses exercise discretion in assigning patients to nurses. Assignments are based on the number of patients the RN or LPN is

28

assigned; the skill of the nurse, i.e., whether they are comfortable with pediatric patients; the stress level of the nurse; and the acuities of the patient. For instance, if there are four patients with high acuities, the charge nurse attempts to assign one patient to each nurse. Krasher

testified that the charge nurse may move a patient from one nurse to another if a nurse has too many patients with high acuities. Charge nurses assign RNs to new admissions coming onto the unit. Admissions are assigned based on work load. The charge nurses can adjust staffing based on changes in the unit, like emergencies or discharges, but only after discussion with the nursing supervisor.

There are normally one or two CNAs assigned to 3 Spellman, depending on the shift.

CNAs are assigned geographically, i.e., two CNAs split the unit in half. 23 CNAs report to the charge nurse when they need to take a break or have an issue with a patient.

According to

director of surgical services Krasher, the charge nurse can talk to a CNA regarding a disciplinary issue, or can call the nursing supervisor about a problem with a CNA. Although Krasher

testified that the charge nurse can issue a verbal counseling and can recommend that staff receive formal discipline, Krasher provided no examples of any charge nurse issuing a verbal counseling to an employee, and did not recount any instances where she considered the input of a charge nurse in deciding to issue discipline.

Director of surgical services Krasher testified that she gets input from level III charge

nurses regarding CNAs that are having problems performing certain duties, such as inputting

vital signs into the computer. The record does not disclose whether level II RNs provide input

on CNAs, nor does the record disclose what happens to CNAs as a result of this input.

Director of surgical services Krasher testified that when she evaluates RNs, she takes

23 The record does not disclose who makes the CAN assignment.

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Alejongarcia's recommendations into consideration because Alejongarcia is a long-time RN and

is very familiar with the staff. According to Krasher, she might take recommendations from

other long-time nurses like level III RN Aquino. Krasher testified that on one occasion, she

decided to extend the probation of a new employee based on Alejongarcia's recommendation as

the employee's preceptor. Krasher stated that she would take seriously a similar recommendation from a level II preceptor.

Stephen Sommer is a level III RN on 3 Spellman. Sommer testified that he became a

level III to increase his salary. Sommer has been on 3 Spellman for ten years and ten months.

Sommer normally works the 7:00 a.m. to 7:00 p.m. shift two days a week, and the 7:00 a.m. to

3:00 p.m. shift two days a week. Sommer rotates as the charge nurse on 3 Spellman for one

shift every other week. He testified that he does not have to perform charge duties in order to

maintain his level III, and that serving as charge nurse is voluntary. Sommer testified that he

does not receive extra money when he is acting as charge, although he recently received a \$1.00

per hour raise for longevity.i"

Sommer testified that the daily assignment sheet is normally filled out by the night

nurses, and is usually divided up by patients, with the goal of equalizing the patient load among

the nurses. According to Sommer, on 3 Spellman, the goal is to have three RNs per shift.

Sommer testified that when he is charge, he carries a full patient load, and has no

discretion to carry a lighter load. According to Sommer, when an admission comes onto the unit,

24 In its post-hearing brief, the Employer claims that Sommer testified

dishonestly. I note that the Employer could

easily have resolved the ambiguity in the record by providing payroll records substantiating the testimony of its

witnesses that rotating charge nurses receive \$1.00 per hour while serving in the charge capacity. The Employer's refusal to do so, especially in light of an outstanding subpoena requesting these documents, supports an inference that the documents, if produced, would not be favorable to the Employer in meeting its burden in demonstrating that the rotating charge nurses draw extra pay when serving in the charge capacity. See, e.g., *RCC Fabricators, Inc.*, 352 NLRB No. 88 (June 9, 2008) (where the Board endorsed the decision of the administrative law judge in drawing an adverse inference against the employer for failing to produce documents within its control).

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the nursing supervisor calls him with the patient's name and diagnosis. If Sommer tells the nursing supervisor that there is an empty bed on the floor, the patient is placed in that bed. If there is no empty bed, Sommer contacts the nursing supervisor when a bed becomes available.

Sommer testified that a nursing supervisor may also call the floor to transfer a patient from another unit, such as ICU. According to Sommer, when an admission comes on the floor, he assigns it to the RN with the fewest patients, and adds the patient to a list on a clipboard.

Sommer testified that he sometimes makes patient assignments for the next shift.

According to Sommer, the starting point in making assignments is an attempt to assign patients to the nurses who took care of them the night before for purposes of continuity of care, but he may make adjustments to ensure an even workload. According to Sommer, he does not factor in the skill of the RNs when making assignments because the assumption is that all RNs can perform all necessary duties, or they would not be employed on the unit. Sommer stated that he

does factor in patients that require a heavy level of care when making assignments. According to

Sommer, when he is not performing charge duties, it is his perception that the RNs' workloads are fairly equal.

According to Sommer, he has never directed staff to stay over or come in early, and has never authorized overtime. Sommer stated that he has never called staff to come in, nor has he

asked staff to stay over. Sommer stated that the nursing supervisor performs those tasks on the weekend, or the clinical coordinator or manager on the weekdays. Sommer always complies with the staffing numbers, and has never called a nurse in on his own initiative. Sommer does not consider himself a supervisor when he is acting in the charge capacity, and testified that staff do not consider him a supervisor. Noone from management has ever represented to Sommer that he is a supervisor.

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If an employee calls off work on 3 Spellman, the nursing supervisor contacts Sommer to let him know. Sommer stated that if he is short-staffed, he does not speak to the nursing supervisor about it because she is aware of staffing on all the units. He testified that sometimes the nursing supervisor contacts him and tells him she is sending a float nurse over. Sommer stated that he has no authority to issue discipline, or to authorize overtime. Sommer stated that he has never been disciplined because a CNA or LPN failed to perform a task, and he is not evaluated on whether the CNAs and LPNs perform designated tasks. Level III float pool RN Kaiser testified that on 3 Spellman, there are normally four or five patients per nurse, and that staffing is based on room numbers, with rooms near each other assigned to the same nurse. The only exception is the isolation rooms, where patients are divided equally among nurses. Kaiser has never been disciplined because a CNA did not perform a duty, and she does not know of an RN who has been disciplined because of performance issues with a CNA.

Mental Health: Beverly Chick is the administrative director for patient care services for the Employer. She is responsible for the endoscopy, maternity and mental health (MH) units.

Chick works from approximately 6:00 a.m. or 7:00 a.m., to approximately 3:00 p.m. or 4:00

p.m., Monday through Friday. Deb Magill is the nurse manager for MH and Laurie Muscari is

the clinical coordinator for MH. Both work day shifts, Monday through Friday.

Administrative director Chick testified about the operations and charge duties of RNs in the mental health unit. There are approximately 21 level I and II RNs, 9 level III RNs, one level

IV RN and an LPN in mental health, as well as mental health technicians, social workers,

activity therapists, occupational therapists and unit coordinators. There are two mental health

units: 2 SMC, an acute 21-bed unit for patients admitted from the emergency room for

32

evaluation; and 2 South, where less acute patients stay while preparing for discharge. Fern Stein,

a level III RN, is normally the rotating charge nurse in the mental health unit.

Stein works from

7:00 p.m. to 7:00 a.m., three to four nights a week. The record does not disclose which RNs, if

any, perform evening charge duties when Stein is not working. Level III RN Hope Wootan

sometimes acts as rotating charge nurse. Wootan works from 7:00 a.m. to 7:00 p.m. and is

normally the charge on the weekend shift. Both Wootan and Stein perform charge duties on both

mental health units. Rotating charge nurses have patient care responsibilities when they are

performing charge duties. According to Chick, all RNs acting in the charge capacity perform the

same duties.

Unlike most other units in the hospital, staffing in mental health is done on the unit and

not by staffing coordinator Graziano. Administrative director Chick and clinical coordinator

Muscari do the staffing during the day, and Stein does it at night. The staffing guidelines call for

four RNs in 2 SMC and two RNs and one LPN in 2 South. According to Chick, mental health

rotating charge nurses know that there are exceptions to the staffing guidelines, such as times

when there are two one-on-one patients on the unit, 25 or three or four patients who are delusional,

borderline or difficult.

Mental health is a closed unit, meaning no staff float on or off the unit.

Administrative

director Chick testified that rotating charge nurse Stein handles staffing issues.

According to

Chick, Stein does not have to check with the nursing supervisor before calling someone in, asking someone to stay, or sending someone home.

Staffing in mental health is predetermined by a color-coded system. Patients are 25 These are patients who require a staffmember to be in attendance at all times. 33

designated one of four colors based on their treating physician, and are grouped by color. Each nurse is automatically assigned all of the patients in a color group.

Administrative director Chick testified that the rotating charge nurse can decide to transfer a patient from one RN to another if an RN has too many difficult patients in one color group. Other times, switches are made based on personalities. If the RN and the patient do not have a therapeutic relationship, then the rotating charge nurse must switch the patient to an RN with whom they can enjoy a therapeutic relationship. Although admissions are assigned automatically based on the order in which they come in, Chick testified that the rotating charge nurse would not assign a very psychotic patient to an inexperienced RN. The rotating charge nurse also attempts to schedule around situations where an RN and patient might know each other. If a patient acts out against a particular RN and the RN feels threatened, the rotating charge nurse will transfer the patient to another RN. Outside of these exceptions, the RN assigned, for example, to treatment team green gets the green patients, and so on.

Mental health technicians have standard duties, most importantly to check the observation board. Vital signs are a routine part of the technicians' duties, as is bathing of patients and checking rooms for contraband. Technicians are instructed to give baths, collect specimens, feed patients, observe patients at 15-minute intervals, take patients out to the patio, or accompany patients who leave the floor for testing. There is no evidence in the record as to how the rotating charge nurse makes decisions about these assignments. According to administrative director Chick, Wootan makes out the daily assignment for the day shift for 2 SMC when she is acting as rotating charge nurse, and gives technicians their assignments both verbally and in

writing. Chick testified that the other RNs on 2 SMC make assignments as well, although the record does not disclose which RNs and what assignments she refers to. Chick stated that the

34

technician assignments might change if a patient is acting out, or Wootan might call in another technician to help with breaks.

Administrative director Chick testified that Stein is responsible for assigning work to

technicians and making sure that they are performing their assessments.

Technicians advise

rotating charge nurse Stein when they are going off the unit. Stein tells technicians when a

patient needs to be walked or toileted, and follows up to ensure it is done. There are two

technicians on the floor until midnight, after which there is only one technician on duty. If a

technician is assigned a one-on-one, the rotating charge nurse can call someone in to assume the

technician's other duties. Technicians are responsible for checking patients who might be a

threat to themselves or to others every fifteen minutes and then documenting it.

Technicians can

be terminated for failing to do so, but there is no consequence to the rotating charge nurse when

a technician does not carry out his/her responsibilities.

Maternity: There are two nurse managers and 22 RNs on the maternity unit, including 10

level III RNs and one level IV RN. Administrative director Chick testified that the level III and

IV RNs rotate charge duties when the nurse manager is off. Chick testified that the nurse

manager designates the rotating charge nurse prior to the commencement of the shift, and that

the rotating charge nurse prepares the daily assignment. According to Chick, the rotating charge

nurse can adjust staffing by calling someone in or calling them off. If the census increases

because more women come into labor, it is standard procedure for the charge nurse to call in

extra staff. If there is a problem with a patient, the RN will convey the problem to the charge

nurse, who contacts the nursing supervisor.

Endoscopy: The endoscopy department operates from approximately 6:30 a.m. to

approximately 6:00 p.m., depending on the schedule of the physicians. There are 11 RNs in

35

endoscopy, including 3 level III RNs and one level IV RN. The RNs who work in endoscopy are also on call nights and weekends.

Level III RN Wendy Bodenweber is charge every Wednesday, and level IV RN Mary

Priede is charge the remainder of the week. Administrative director Chick testified that as

charge nurses, they call staff in if needed. The record demonstrates that the standard procedure

in endoscopy is to rotate RNs throughout the three areas. For example, an RN who works one

week in recovery works the next week in procedures and the next in assessment.

There are some

RNs who are stronger in one particular procedure and tend to stay there. The record does not

disclose whether RNs voluntarily remain in the procedure in which they are most competent, or

whether it is mandated by the Employer.

Oncology: Rosa Keane is the nurse manager for oncology on 4 SMC. This department is

a 17-bed inpatient unit and deals with cancer care, works with hospice, and takes some overflow

from the rest of the hospital. There is also an outpatient infusion room where patients receive

chemotherapy. Keane testified that there are 19 RNs, one LPN, CNAs, clerks and per diems on

the unit. Keane and clinical coordinator Michelle Donovan work the day shift, Monday through

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Friday.

Nurse manager Keane testified that level III oncology RN Khristine Sykes normally

works a 7:00 p.m. to 7:00 a.m. schedule three days a week, and is the charge nurse almost every

time she works. Level II RNs in the oncology unit also perform charge duties.

Sykes is not a

titled charge nurse; her job description is staff RN. Keane testified that Sykes creates the sixweek

schedule for the unit nurses to write in their time-off requests, balances the schedule, and

gives it to Keane for her approval. Sykes performs this duty to satisfy her level III requirements

discussed above.

Nurse manager Keane testified that when Sykes is performing charge duties, she monitors the flow of work on the unit, provides assistance to staff and collaborates with the nursing supervisor. Sykes has her own patients to care for she is acting as charge nurse.

Nurse manager Keane initially stated that if staff call in to be excused from work, Sykes

calls the nursing supervisor and advises her that she is going to initiate phone calls to call staff

in. However, if the nursing supervisor determines that no staff should be called in, her decision

prevails. If someone calls off work for the day shift, Sykes contacts Keane to let her know. Like

the other charge nurses, Sykes can solicit volunteers to stay over if the unit is busy.

The clinical coordinator makes the evening shift assignment. Staffing guidelines generally call for three RNs on the evening shift, and two on the night shift. Nurse manager

Keane testified that Sykes decides which patients go to which nurse, based on the skill level of

the staff member. Keane testified that Sykes normally takes leukemia patients for herself, or

assigns those patients to another nurse with the skill to care for them. Sykes has never been

disciplined based on staffing decisions.

Level III float pool RN Jennifer Kaiser testified in great detail about staffing on the oncology unit. According to Kaiser, all oncoming nurses sit in the report room while each RN

going off duty gives report to all oncoming nurses. This method ensures that all nurses coming

on duty are aware of the status of all patients on the unit. According to Kaiser, after receiving~

report, the RNs report to the desk and one of the nurses, not necessarily the charge nurse, takes a

piece of paper, writes down the names of all the patients, and the nurses select which patients

they want to care for. Kaiser testified that assignments are done in this manner because

oncology patients are often longer term than other patients, and the RNs form relationships and

like to care for the same patients. Kaiser stated that as the float nurse, she normally gets the

patients no one wants or is able to take. If there are enough nurses on duty, one nurse will take

the chemotherapy room for the day. Kaiser said the goal is to distribute the patient load as evenly as possible. Kaiser testified that she has never worked with rotating charge nurse Sykes. According to nurse manager Keane, Sykes can tell a CNA that she needs to monitor a patient more often. Keane stated that physicians call Sykes with direct admissions, and Sykes decides whether it is appropriate to have the patient come to the floor. If patient 'is not appropriate for admission to the unit, Sykes directs the physician to the nursing supervisor. Keane could not recall any specific incidents of when this has occurred. Nurse manager Keane testified that she seeks input from Sykes on the performance of the night staff, such as whether they are performing assessments properly. Keane testified that she asks Sykes about various factors regarding an employee's appraisal, such as patient assessment and communication skills. Keane testified that she gives substantial weight to Sykes' input because she is familiar with the work performance of the night staff.

Level III and IV RNs

Julia Motti is a level IV RN who has worked in the post-anesthesia care unit since 1980.

Motti stated that her understanding is that the clinical ladders were put into place as a way to move up professionally without going into management, and that is why she did it. Motti has never been told that she is a supervisor, and does not consider herself a supervisor. She has no involvement with any labor relations policies, personnel policies or procedures. She is not involved in appraising employees, or giving appraisals. Motti does not discipline, hire, fire, layoff, transfer or assign work to employees.

The record demonstrates that all of the five RNs in the post-anesthesia care unit are levels

III and IV. There is no charge nurse in the post-anesthesia care unit. Motti does not perform

38

charge duties and is not aware of any level III or IV nurses who perform charge duties to satisfy the clinical requirements. Motti teaches certification classes to maintain her level IV, and she participates in the Collaborative Practice Council, discussed below

Mary Sue D'Orazio is a level III RN. She has worked in the ambulatory surgery unit for approximately 12 years. D'Orazio testified that when the clinical advancement program was initiated several years ago, it was her understanding that it was designed as a means for nurses who wanted to maintain bedside nursing positions, but were not interested in supervisory or managerial positions, to earn more money. D'Orazio testified that director of surgical services Krasher told her that the clinical ladder was for nurses not interested in supervisory or management positions. D'Orazio has never been told that she is a manager or supervisor by virtue of her level III status, and she does not consider herself a manager or supervisor.

D'Orazio does not hire, fire, assign work or tasks, or evaluate coworkers.

D'Orazio testified that

she has never had to perform charge duties to maintain her level III.

There are three hospital-wide councils: the Quality Assurance/Quality Improvement

(QA/QI) Council; the Collaborative Practice Council; and the Education Council. The QN/QI

Council is composed of 60 percent staff and 40 percent management. Although level III and IV

nurses comprise the majority of staff members on this council, level II RNs may also participate

in the council. The members of this council work on policies specific to the Employer's quality

assurance program. Policies are discussed and voted on at council meetings, and are distributed

to the staff either by council members or by posting.

The Collaborative Practice Council is composed of approximately 70 percent staff. This

council reviews, revises and develops patient care services policies. Vice-president of patient

care services Lunney and the council chairs, level III RN Jill Towns and level IV RN Brenda

39

Relyea, sign off on the policies. Level IV RN Julia Motti testified that all policies and

procedures passed in this council must be approved by the vice-president of patient care services

or someone in a similar position.

The Education Council is composed of 60 percent staff and 40 percent management. It is

co-chaired by two staff members: one level III and one level IV RN. The council meets once a month, and discusses educational issues that need to be disseminated to the staff. The council also worked on Skills Day, which is an annual competency program that the RNs are required to complete. The council reviews a different policy each month. The facilitator makes the changes discussed by the council. After a policy is approved by the council, it goes to human resources to be reviewed by the Employer's human resource director, Heidi Rosborough, before dissemination to the staff by the council.

Level III RN Stephen Sommer participates on the Surgical Improvement Committee.

Sommer testified that he does not draft or sign off on policies, nor does he vote policies up or

down. Level III float RN Jennifer Kaiser testified that when she was on the Education Council,

she never drafted or voted on policies. Level III RN Mary Sue D'Orazio is on the Education

Council and the unit-based Surgical Collaborative Practice Council. D'Orazio stated that she

does not write policies or sign off on policies on either council. The record demonstrates that

the RNs who participate on these councils sometimes miss the meetings because they are unable

to leave their patient care responsibilities.

Some RNs complete unit projects in order to maintain their level III status. Level III RNG

Kerri Deangelis in the ambulatory surgery unit and Khristine Sykes in oncology prepare the sixweek

schedule for their units, which are then reviewed by their respective managers.

Level III

RN Sommer is involved in overseeing equipment safety on 3 Spellman for his level III status.

40

Director of surgical services Krasher testified that level III and IV RNs give direction to

LPNs and CNAs while acting as charge nurses and while engaged in their patient care duties.

The record demonstrates that level II RNs also act as charge nurses, and that all RNs direct LPNs

and CNAs to complete certain tasks. All RNs ensure that the CNA carries out the physician's

orders. The record reveals no evidence that any RN is held accountable for the work performed by LPNs or CNAs.

If an RN is assigned a patient who has an LPN assigned to him/her, the RN is responsible for handling functions that the LPN is not permitted to perform, and directing the LPN in

carrying out the orders of the physician. The record demonstrates that this responsibility inures

to all RNs, not just level III and IV RNs. The record contains no evidence that an RN has ever

been held accountable for the work performed by an LPN.

The Employer has a preceptor program, wherein the Employer partners new RNs with

... experienced RNs for training purposes, which consists of a 6 to 12 week program for newly

graduated nurses, or a two to three week program for nurses coming in from other hospitals. The

record demonstrates that level II RNs also act as preceptors, and that any RN on 4 Spellman,

which only has one level III RN, can mentor a new nurse.

Precepting by level III and IV RNs is voluntary, and RNs do not have to precept to

achieve level III or IV. RNs who choose to do so can become preceptors by taking a preceptor

course offered by the Employer. RNs engaged in precepting duties carry a patient load while

performing their precepting duties." Level III RN Sommer testified that he has precepted but

has never been evaluated on the quality of his precepting. Contrary to the Employer, Sommer

testified that the preceptor program is informal. According to Sommer, the orientee maintains a

26 The Employer tracks RNs who are performing precepting duties by a time detail report, which codes the time

spent by each RN in, inter alia, charge and precepting duties.

41

list of skills and the preceptor checks items off the list as the orientee masters the various skills.

Sommer testified that the list contains very basic skills. Sommer stated that the clinical

coordinator asks how the orientee is doing, and he gives his opinion. Sommer has never told the

clinical coordinator that an orientee cannot perform a task on the checklist.

According to

Sommer, all the RNs on 3 Spellman have precepted at one time or another. Nurse manager Drake testified that staff RNs act as preceptors on 3 SMC, but only those that rotate as charge nurses. The record contains no evidence as to whether this is the Employer's policy, or the result of limited opportunities for preceptors or a lack of RNs interested in precepting on 3 SMC. Level III RN Jill Towns is currently precepting, and has been a primary preceptor on 3 SMC for the last two to three years. According to Drake, her input is given 90 percent weight in determining capabilities of new nurses. Drake testified that on one occasion, she decided not to take an employee off probation based on Towns' recommendation. On cross-examination, however, Drake testified that the particular orientee had failed her licensure boards twice and was prohibited from working on the floor based on hospital policy.

Administrative director Chick testified that level III RN Stein has been a preceptor for approximately 5 to 10 years. According to Chick, orientation can be extended based on a preceptor's recommendation. Although Chick testified that several RNs have had their orientations extended because of the recommendation by the preceptor, Chick could recall no specific details about these extensions. Chick testified that all of the level III and IV RNs in mental health have been preceptors. Chick stated that level II nurses can also act as preceptors. Level III and IV nurses cannot incur expenses on behalf of the hospital, and cannot discipline employees. Level III and IV RNs have no authority to verbally counsel employees.

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Although administrative director Chick testified that level III and IV RNs can let staff leave early, she can recall no occasion when that has happened. The Employer's policy on overtime work is to permit it when needed to staff the units. Clinical nurse specialists The Employer asserts that clinical nurse specialists Marcie Truesdale and Arlene. Cohen

are supervisors pursuant to Section 2(11) of the Act. Truesdale is a part-time employee. She spends half her time on 3 SMC and half her time in the intensive care unit. Truesdale teaches a critical care course for new graduates. She is the resource person for nurses that have questions about advanced practice and anything clinical. Cohen, also part-time, works on the oncology unit. Both Truesdale and Cohen report directly to Kathy Lunney, vice-president of patient care services.

Level III float RN Kaiser testified that Truesdale teaches EKG classes and a 10-week intensive care unit course. Truesdale asked her for some documents a couple of months ago regarding Kaiser's level III status. She has never seen Truesdale direct work or assign patients.

Arlene Cohen is in charge of education for all staff. Cohen has an office in front of the nurses' station on 4 SMC. Cohen assists in research, sits on councils, creates educational opportunities for staff with outside sources such as drug representatives, assists in cancer screenings, and helps raise funds for different organizations. The record demonstrates that

Cohen's primary function appears to be keeping abreast of new medications and procedures in oncology research, and then passing the information and skills along to the staff. To that end,

Cohen teaches staff about new medications and how to administer them, teaches new staff about IV therapy, and teaches existing staff about updates in IV devices. Cohen reviews medications

each day with nurses who are giving chemotherapy to make sure they understand the side effects

43

and symptoms. She distributes articles to nursing staff on new treatments and medications,

keeps education folders on every member of the oncology staff, including nurse manager Keane,

prepares and grades examinations for staff, and makes sure staff is in compliance with education requirements. 27

Nurse manager Keane testified that Cohen is responsible for reviewing patient files as

part of her staff education duties. Keane testified that Cohen supervises staff when she and

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Donovan are not there. The record contains no examples of such supervision.

Level III float

staff RN Kaiser testified that she has never been told that Cohen is a supervisor.

Kaiser stated

that she has never seen Cohen assign work.

According to nurse manager Keane, she and Cohen review policies. Keane testified that

a few weeks prior to the hearing, Keane created an education board as a result of a problem that

an RN had in administering a chemotherapy treatment. Cohen worked with the RN to make sure

the proper treatment and antidote were administered to the patient, and then met with Keane to

discuss the incident. Keane testified that she and Cohen create competencies, which are-actual

skills needed to perform procedures. Keane stated that either she, clinical coordinator Donovan,

or Cohen can sign off that a nurse is able to perform a particular procedure.

Cohen maintains an education board for staff that changes monthly. She

familiarizes

herself with certain treatment regimens and teaches them to staff. Cohen rarely performs patient

care services.

Nurse manager Keane testified that she works with Cohen on appraisals, and if Keane

27 The examinations cover, for example, staff knowledge of the articles on treatment and medications that Cohen

distributes. The record does not disclose the impact of these examinations or staff noncompliance with educational

requirements has on terms and conditions of employment.

44

does not know how an RN is performing on documentation, she checks with Cohen. Keane

testified that Cohen assists in grading staff on communications with patients, physicians, and

delivering education to patients; and that Cohen reviews quality assessment and improvement by

looking at positive patient outcomes and ensuring that the pain audit filled out by the nurses

meets standards of care. Keane testified that if she administers a written warning to staff, either

clinical coordinator Donovan or Cohen sit with her. Keane testified that two or three weeks prior

to the hearing, she and Cohen sat down with a CNA and told her she was terminated. The record contains no evidence regarding whether Cohen was involved in the decision to terminate the CNA, or what her role is in these meetings with employees. Nurse manager Keane testified that Cohen attends a management meeting once a month with nurse managers, clinical coordinators, and clinical nurse specialists. Cohen is on the Education Council and the Collaborative Practice Council. Keane testified that Cohen creates and revises policies. These policies are reviewed by more than 10 people before they are approved, and are usually signed off on by the vice-president of patient care services. Keane testified that Cohen recently revised the neutropenic policy (very low white blood cell count), and after Keane reviewed it, Cohen took it to the Collaborative Practice Council for approval." Cohen also created a policy regarding patients receiving chemotherapy for hypersensitivity and anaphylaxis, and she creates standing orders (step by step procedures) for policies. Cohen presents policies at the Collaborative Practice Council, and she gets input on these policies from oncologists and the cancer committee. Either Cohen or Keane present these policies to the staff, or they put it up on the bulletin board and have staff initial that they have read and understood the policy.

28 The record does not disclose whether the policy was approved.

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ANALYSIS

Premature Petition and Scope of Unit Issues

The Employer contends that the petitioned-for unit is inappropriate because it is premature based on imminent and substantial changes to the bargaining unit and because certain

registered nurses in the petitioned-for unit will be employed by a joint employer, Nistel, which

has not been a party to this proceeding. The Employer further argues that the petitioned-for unit

is inappropriate because it does not include non-supervisory nurses employed by Kingston.

I find that the Employer has presented insufficient evidence that the petitioned-for unit of

the Employer's RNs is inappropriate. In this regard, I note that the record fails to demonstrate

that the proposed bargaining unit will undergo any substantial and imminent changes on any date

certain that will render the proposed unit an inappropriate unit for purposes of collective

bargaining.

The Employer argues that the petition is premature because, at some point as a result of

the consolidation of the services of the two hospitals, as many as 200 Kingston RNs will be

excluded from the bargaining unit. The Petitioner argues, to the contrary, that the consolidation

of services is speculative and is not a basis for dismissing the petition. Although I do not agree

that the consolidation itself is speculative, I find that the record fails to demonstrate that the

alignment of the hospitals will result in an imminent and substantial change to the bargaining

unit that will render the proposed bargaining unit inappropriate.

The Board will dismiss a petition for an election as premature where the party challenging the petition demonstrates that the composition of the proposed bargaining unit is

about to change drastically as a result of imminent and substantial changes. It is well settled,

however, that even in the face of a changing unit composition, the Board will direct an

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immediate election when the employer's current complement of employees is "substantial and

representative" of the unit workforce to be employed in the near future. In re Yellowstone

Intern. Mailing, Inc., 332 NLRB 386 (2000); Toto Industries (Atlanta), 323 NLRB 645 (1997).

There is no bright line test for when the Board will find a petition premature.

However,

the Board has routinely declined to dismiss a petition for an election in the absence of evidence

that the proposed change will occur at some date certain within the near future.

In Bekaert Steel

Wire Corp., 189 NLRB 561 (1971), the Board denied the employer's request to dismiss a

petition, claiming that the petition was premature based on its plans to construct a new

production facility that would greatly increase its production capabilities and require a larger and

more-skilled work force. The Board disagreed, noting that the scheduled completion date of the new production facility was too distant and speculative to warrant dismissal of the petition:

On the basis of the record before us, we find that the evidence adduced by the Employer in support of its contention that the petition is premature is not sufficient to establish that those working in the bead wire operation should presently be denied an opportunity to express their free choice in an election. While the Employer's witnesses estimated that the new plant might be ready as early as July 1971, the record as a whole indicates that the date when its expansion plans will be completed is uncertain. A number of events must occur before the new plant is built and ready to begin production; as of November 1970, none of these events had occurred.

Similarly, in *Laurel Associates, Inc.*, 325 NLRB 603 (1998), the Board denied review of

a regional director's decision directing an election over the employer's claim that the petition

was premature. In that case, at the time of the hearing, the employer employed approximately 68

employees in the unit sought by the petitioner. The employer asserted that it planned to apply for

an increase of 30 beds in the near future and further asserted that it would require 120 unit

employees to fully staff the facility once it was at full capacity (achievable within 12 months).

47

The regional director noted, however, that the record was devoid of any evidence regarding the

rate of expansion in the future or evidence of anticipated real increases in capacity. As such, any

determination as to when, if ever, the employer would be operating at full capacity was mere

speculation and did not warrant denying the employees their statutory right to an election.

I find, in agreement with the Petitioner, that the consolidation relied on by the Employer

in seeking to dismiss the petition is highly dependent on a series of phased construction projects,

with certain phases requiring completion before other construction projects can begin. My

decision is bolstered by evidence that, as of the time of the hearing, construction had not

commenced at either hospital, and Foxhall Ambulatory Surgery Center was still in the bidding

process.

Even assuming the scenario most favorable to the Employer, that the alignment plan that is contained in the record will be executed as anticipated by the parties, the only evidence in the record regarding a time frame for the final unit configuration is that the construction must be completed no later than December 2009, more than 17 months after the close of the hearing in this case. This time frame, as well as the ambiguity in the record, is insufficient to deny the Employer's existing employees the right to seek representation in an immediate election.

Likewise, I do not find that the petition is premature based on the anticipated migration of the Employer's and Kingston's RNs to each other's facilities over the course of the next 17 months. Rather, I find that this migration of employees does not constitute a substantial change

that warrants dismissal of the petition. In this regard, I find that the record demonstrates that the

Employer's RNs who will relocate to Kingston on either a temporary or permanent basis will continue to be employed only by the Employer, and the Kingston RNs who relocate to the

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Employer will continue to be employed only by Kingston?9 The record demonstrates that the

RNs, irrespective of their locations, will operate under the terms and conditions of employment

set by their respective hospitals, and will be subject only to the disciplinary policies of their

home hospitals. The Employer's RNs located at Kingston will swipe in and out on time clocks

the Employer plans to purchase and locate at Kingston, and Kingston RNs will swipe out in and

out only on their own time clocks, which will be located at the Employer's facility.

Thus, the

record demonstrates that the two sets of RNs will continue to work under the terms and

conditions of employment set by their respective hospitals.

I further note that the record demonstrates that the Employer does not plan to either

increase or decrease the number of RNs in the proposed bargaining unit as a result of the

consolidation of services with Kingston. In light of the above factors demonstrating no definite timeframe for the final unit configuration and the absence of any evidence that the unit will undergo a substantial change as a result of the consolidation, I find the Employer has failed to demonstrate that the petition is premature. Regarding the Employer's claim that the petitioned-for unit is inappropriate because it does not include employees employed by Nistel, I note that the record contains no evidence that Nistel employs any individuals in the proposed bargaining unit. Although the Employer provided an administrative service agreement between HAP and Nistel, the record does not disclose when Nistel will hire any RNs in the petitioned-for unit, and does not disclose the rate at which Nistel will hire RNs in the proposed bargaining unit. Finally, I note that the record contains conflicting evidence even as to the number of RNs Nistel might ultimately employ. Thus, in the absence of any evidence that Nistel actually employs any employees sought by the

29 The record does not disclose the number or percentage of the Employer's or Kingston's employees who will ultimately be relocated.

49 instant petition, or that it will actually employ a specific number of the Employer's employees on any date certain, I find that Nistel is not a joint employer in this proceeding." To the extent that the Employer argues that the petitioned-for unit is inappropriate because it does not seek to include RNs employed by Kingston, I note that no party to this proceeding has asserted that Kingston and the Employer are joint employers of any RNs eligible for inclusion in the petitioned-for unit. In this regard, the Employer has consistently maintained during the representation hearing and in its post-hearing brief that Nistel and the Employer are joint employers in this proceeding. I further note that Kingston's president and chief executive officer Michael Kaminski testified at the hearing and did not assert that Kingston employs any of the RNs eligible for inclusion in the bargaining unit. Finally, and most significantly, the

Petitioner does not seek to represent RNs employed by Kingston. While the Employer makes no claim that Kingston and the Employer are joint employers, it conversely argues that the Kingston RNs must nonetheless be included in the bargaining unit. I note that the record demonstrates that the two hospitals remain separate and distinct entities. In this regard, I note that the hospitals' human resource departments operate independently from each other, and each hospital maintains its own employment policies, and determines its own wages and benefits. To the extent that the Employer's RNs and Kingston's RNs will be jointly supervised by one direct supervisor in consolidated departments, the record demonstrates that these individuals will be instructed to supervise employees in accordance with the employment policies of their respective hospitals. Thus, the record fails to demonstrate that either entity exercises control over the labor relations of the other, and the record clearly demonstrates no

30 Based on my finding that the Employer and Nistel are not joint employers, and as Petitioner does not seek to represent any employees of Nistel, it is unnecessary to address the Employer's argument that, under the Board's holding in *Oakwood Care Center*, 343 NLRB 959 (2004), Nistel's consent is required for the inclusion of its yet-to-be-hired employees in the unit.

50 history of collective bargaining by either the Employer or Kingston that warrants the inclusion of the Kingston RNs in the proposed bargaining unit. Accordingly, I find, contrary to the Employer, that there is no basis for concluding that the petitioned-for unit must include RNs employed by Kingston. See, e.g., *Hunts Point Recycling Corp.*, 301 NLRB 751 (1991); *Meat Packers Association*, 223 NLRB 922 (1976) (A single-employer unit is presumptively appropriate. A party urging a multiemployer unit must demonstrate a controlling history of bargaining on a multiemployer basis and an unequivocal intent by the employer to participate in and be bound by the results of group bargaining). The Employer also argues, inter alia, that a multi-facility unit consisting of RNs at both

the Employer's and Kingston's campuses is the only appropriate unit herein. In making this argument, the Employer erroneously claims that the Petitioner seeks to represent only those RNs located at the Employer's 105 Mary's Avenue, Kingston, New York location. The record demonstrates, however, that the Petitioner seeks to represent all full-time, regular part-time and per diem RNs employed by the Employer wherever they may be located, including the Kingston facility. Inasmuch as the parties agree that the appropriate unit includes RNs located at both the Employer's and Kingston's facilities, and the record demonstrates that the Petitioner seeks to represent the Employer's RNs at both facilities, I need not decide whether the single-facility presumption has been rebutted. See, e.g., *Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205 (2003), fn. 10 (where the Board found that the regional director erred in applying the single-facility presumption where the petitioner was seeking a multi-facility unit). Finally, I note that, in the event that the bargaining unit is rendered inappropriate at some point as a result of the alignment of the two facilities, any party can seek resolution of any unit

51

issues that arise in a subsequent appropriate Board proceeding. See *Bekaert Steel Wire Corp.*, 189 NLRB at 562.

Supervisory issues

Section 2(11) of the Act defines a statutory supervisor as any individual with the authority to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward or

discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such

authority is not of a merely routine or clerical nature, but requires the use of independent

judgment. It is not necessary that the individual possess all of the specified powers; rather,

possession of any one is sufficient to confer supervisory status. *Chicago Metallic Corp.*, 273

NLRB 1677, 1689 (1985).

The party asserting that an individual has supervisory authority has the burden of proof.

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Dean & Deluca New York, Inc., 338 NLRB 1046 (2003); NLRB v. Kentucky River Community

Care, Inc., 532 U.S. 706, 713 (2001). Purely conclusory evidence is not sufficient to establish

supervisory status; rather, the party must present evidence that the employee actually possesses

the Section 2(11) authority at issue. Golden Crest Healthcare Center, 348 NLRB No. 39

(September 29, 2006). A "paper showing" or testimony merely asserting generally that

individuals exercised certain supervisory duties is not sufficient to meet the burden of proof.

Rather, the testimony must include specific details or circumstances demonstrating the existence

of supervisory authority. Avante at Wilson, Inc., 348 NLRB No. 71 (October 31, 2006).

Individuals are statutory supervisors if they hold the authority to engage in anyone of the

twelve supervisory functions (e.g. assign or responsibly direct); their exercise of such authority is

not of a merely routine or clerical nature but requires the use of independent judgment; and their

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authority is in the interest of the employer. NLRB v. Kentucky River Community Care, Inc.,

532 U.S. 706, 713 (2001).

In Oakwood Healthcare, 348 NLRB No. 37 (September 29, 2006), the Board clarified the

criteria for finding that a purported supervisor "assigns" and "responsibly directs" the work of

others, and uses "independent judgment" in doing so. The Board held that the authority to assign

refers to "the act of designating an employee to a place (such as a location, department, or wing),

appointing an employee to a time (such as a shift or overtime period), or giving significant

overall duties, i.e., tasks, to an employee. *Id.*, slip op. at 4.

The Board further noted that for direction to be responsible, the person performing the

oversight must be held accountable for the actions of others. "Thus, to establish accountability

for purposes of responsible direction, it must be shown that the employer delegated to the

putative supervisor the authority to direct the work and the authority to take corrective action, if

necessary.... and a prospect of adverse consequences for the putative supervisor if he/she does not take these steps." Id., slip op. at 7. Finally, the Board stated that in order to exercise independent judgment, the direction "must be independent [free of the control of others], it must involve a judgment [forming an opinion or evaluation by discerning and comparing data], and the judgment must involve a degree of discretion that rises above the 'routine or clerical.'" Id., slip op. at 8. The Employer does not contend that the titled and rotating charge nurses have the authority to hire, transfer, suspend, layoff, recall, promote, discharge, assign, or reward employees. The Employer contends, rather, that the titled charge nurses and rotating charge nurses are statutory supervisors based on their authority to assign work, responsibly direct staff, 53 adjust staffing levels on the units, effectively recommend discipline and make effective recommendations regarding performance appraisals. Evening/Night Charge Nurses(Titled Charge Nurses)

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I find that the record demonstrates that titled charge nurses Rosella Curry, Jennifer Tatar and Brittany Jones are statutory supervisors within the meaning of Section 2(11) of the Act, based on their assignment of patients to RNs and LPNs in their respective units. In this regard, I note that these patient assignments constitute the designation of significant duties, and that the titled charge nurses exercise independent judgment within the meaning of Oakwood in making these assignments. The record demonstrates that 4 Spellman and 3 SMC are the only units that have designated charge nurses, while the remaining units that utilize charge nurses rotate RNs in the a charge capacity on a voluntary basis. On 4 Spellman and 3 SMC, the titled charge nurses are the individuals primarily responsible for overseeing the flow of work on these two units when the nurse managers and clinical coordinators are out of the building. Although a nursing supervisor

is always on duty and is the highest authority in the hospital, the record demonstrates that the titled charge nurses are the individuals primarily responsible for assigning patients to nurses on their respective units.

Titled charge nurse Curry makes nursing assignments on 4 Spellman. General staffing guidelines call for a ratio of five or six patients per nurse, but the record demonstrates that these guidelines may be adjusted based on the needs of the patient and the experience of the nurse.

For instance, a new nurse will not be assigned to care for a patient requiring expert care.

Although skill levels are generally not considered as all nurses are qualified to work on the floor,

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some nurses are better at certain things or more skilled in certain areas, such as wound care or

respiratory patients, and Curry may factor in these considerations when making assignments.

Curry is responsible for assigning new admissions coming onto 4 Spellman to the RNs.

While the goal is to equalize the workload as much as possible, the record demonstrates that

there are circumstances in which Curry does not automatically assign an admission to the RN

with the fewest patients. If an RN has a patient who is having difficulties, or has several patients

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with high acuities, Curry assigns the admission to another RN. Likewise, certain nurses are

unable to care for isolation patients because of health reasons, and Curry takes this into

consideration when making patient assignments. Also, an RN caring for isolation patients is

generally assigned fewer patients because isolation patients require more of the RN's time.

On 3 SMC, titled charge nurses Tatar and Jones make patient assignments for all three

shifts. Nurse manager Drake testified that, in making the patient assignments, Tatar and Jones

consider the acuity of the patients, and the experience levels of the nurses.

According to Drake,

Tatar is familiar with the training and education of many of the nurses on 3 SMC because she is

a frequent preceptor.

Not all nurses on 3 SMC are qualified to provide care for all patients. For instance, certain RNs have let their stroke certifications lapse, and LPNs cannot administer certain types of medications, like drip medications. In these instances, Tatar and Jones make assignments that accommodate these limitations. According to Drake, if a nurse manager requests that a staff member be floated to another unit, the titled charge nurse makes the decision as to which staff member to send.

I find that the record demonstrates that the titled charge nurses exercise independent judgment in making patient assignments. Although the goal is to equalize workloads, maintain

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continuity of care to the extent possible, and group patients geographically in order to increase efficiency, the record demonstrates that the titled charge nurses consider other factors in making patient assignments. Those factors include the acuities of existing patients and those patients coming onto the floor, as well as the stress level and abilities of the nurses on staff. For instance, if one nurse has four patients, one or more of whom requires a great deal of care, and the remaining nurses all have five patients with relatively low acuities, the charge nurses must use their judgment to make an assessment as to which nurse is best able to take an admission.

The record demonstrates that the titled charge nurses make patient assignments based on the number of isolation patients on the floor and the nurses available to treat them, current certifications of RNs on duty, and LPNs who are unable to perform certain patient care functions. Because isolation patients require more time-intensive care than other patients, isolation patients are distributed equally among the nurses. RNs caring for isolation patients may have fewer patients assigned to them. Accordingly, the charge nurse has the ability to allocate staff resources during the shift by assigning some nurses fewer patients who need more intensive care, while assigning other nurses more patients who require more general care. Thus, the

evidence shows that assigning patients to nurses requires more than just a rote assignment that merely divides patients among available staff. Rather, charge nurses must utilize a significant degree of judgment in making staffing decisions that factor in the needs of the patients, and the abilities of the staff on duty to care for those patients.

In Oakwood Healthcare, Inc., 348 NLRB No. 37 (September 29, 2006), the Board found

that charge nurses who made patient assignments in a fashion similar to the titled charge nurses

at issue in the instant case were statutory supervisors. **In** Oakwood, the charge nurses were

responsible for assigning nurses to care for patients. Although the goal, as in the instant case,

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was to equalize workloads to the extent possible, charge nurses often made staffing assignments

based on the expertise of certain nurses with particularized training, such as chemotherapy or

pediatrics, an evaluation of a given nurse's workload, and the degree of difficulty that some tasks

present. The Board noted that consideration of these factors meant that a charge nurse could

decide which work to assign to which nurses. In so doing, the Board found that the charge

nurses "assign each member of the nursing staff the number and type of patients that each staff

member is capable of handling during the shift." *Id.*, slip op. at 12. In so finding, the Board

stated that:

In our view, where the charge nurse makes an assignment based upon the skill, experience, and temperament of other nursing personnel and the acuity of the patients, that charge nurse has exercised the requisite discretion to make the assignment a supervisory function "requiring the use of independent judgment."

Id.

Similarly, the titled charge nurses in the instant case, by making decisions that impact

both the number of patients assigned to each nurse and the difficulty of those patients, and make

staffing decisions that directly affect the working conditions of the nursing staff.

"[I]n the health

care context, the assignment of a nurse's aide to patients with illnesses requiring more care rather

than to patients with less demanding needs will make all the difference in the work day of that employee." *Id.*, slip op. at 5.

I also note that Curry, Tatar and Jones are the only titled charge nurses employed by the Employer, that Tatar and Jones do not routinely care for patients, and that Curry may not

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carry a patient load. Although not dispositive, these secondary indicia of supervisory authority bolster my finding that these individuals are supervisors pursuant to Section 2(11) of the Act.

See *New York University Medical Center*, 324 NLRB 887, 907 (1997) [in close cases, the Board

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looks to well-established secondary indicia, such as the individual's job title and whether the individual possesses a status separate and apart from that of rank-and-file employees, in determining supervisory status. *NLRB v. Chicago Metallic Corp.*, 794 F.2d 527, 531 (9th Cir.

1986); *Monarch Federal Savings & Loan*, 237 NLRB 844 (1978)].

I find that the Employer has failed to establish that the titled charge nurses make effective

recommendations regarding evaluations of staff that lead to any personnel actions against

employees. The record contains no evidence that Curry participates in employee evaluations.

Although nurse manager Drake testified that she sat down with Tatar and obtained input from

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her when she prepared last year's employee appraisals, Drake failed to provide any specific

testimony about the input provided by Tatar, or the impact such input had on Drake's evaluation

of employees." As noted by the Petitioner in its post-hearing brief, vague, uncorroborated and

conclusory testimony will not establish supervisory status. *Alstyle Apparel*, 351 NLRB No. 92

(December 28, 2007). See also *Avante at Wilson, Inc.*, 348 NLRB No. 71 (October 31, 2006),

slip op. at 2 (evidence that is "utterly lacking in specificity" does not meet the employer's burden

of establishing supervisory status).

I further find that the record fails to demonstrate that titled charge nurses effectively

recommend discipline. Although the Employer contends that charge nurses have the authority to discipline employees, it failed to provide any evidence that any charge nurse, including the titled charge nurses, have actually done so. Nurse manager Jimenez testified that she believes that a charge nurse may have given a warning to an RN, and that the charge nurses can issue verbal warnings, which can be placed in the employee's personnel file that is kept on the floor.

However, the record demonstrates that Curry is required to report all incidences of misconduct to 31Drake testified that because Jones is new in the position of titled charge nurse, she has not yet met with her regarding employee appraisals.

58

Jimenez, and Jimenez always conducts an investigation and makes the determination regarding whether to place a note in the employee's file. Thus, in light of the evidence that Jimenez always investigates any alleged misconduct prior to determining if discipline is warranted, Curry's role, if any, is merely reportorial and does not confer supervisory authority. See *Millard Refrigerated Services*, 326 NLRB 1437, 1438 (1998); *Illinois Veteran's Home*, 323 NLRB 890 (1997).

The record demonstrates that while nurse manager Drake testified that the titled charge nurses have the authority to issue discipline, she provided no evidence that Tatar and Jones have done so. Rather, Drake testified that Tatar spoke to two CNAs about excessive talking, and one RN about documentation. However, the record contains no evidence that these conversations amounted to discipline, that Tatar, Jones or any other charge nurse recommended that employees receive discipline, or that these incidents form the basis for any future discipline. In the absence

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of any specific evidence of the impact that Tatar's conversations, referenced above, had on the employees' job status, I find that the Employer has failed to establish that Tatar effectively recommends discipline. See *Ten Broeck Commons*, 320 NLRB 806, 813 (1996); *Phelps*

Community Medical Center, 295 NLRB 486, 490-491 (1989) (mere reporting on incidents of employee misconduct is not supervisory if the reports do not always lead to discipline, and do not contain disciplinary recommendations; the exercise of disciplinary authority must lead to personnel action, without the independent investigation or review of other management personnel). Cf. Berthold Nursing Care Center, Inc., 351 NLRB No.9 (September 26, 2006), slip op. at 2 (charge nurses exercise independent authority in issuing discipline where they had the authority to write up counseling forms that formed the basis for future disciplinary actions).

Finally, the Employer failed to provide evidence that the titled charge nurses responsibly direct the work of subordinate employees. While it appears that the charge nurses direct LPNs in

59

carrying out the orders of physicians and direct CNAs in certain patient care duties, such as

instructing a CNA to take vital signs or get a finger stick, the record fails to demonstrate that

titled charge nurses are held accountable for this direction of employees.

Accountability, as

defined by the Board in Oakwood, requires some showing that the putative supervisor suffers the

prospect of adverse consequences if he/she fails in the direction of work to others. In the instant

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case, the only evidence of accountability is the fact that titled charge nurses, as opposed to

rotating charge nurses, are evaluated based on the supervision of clinical staff on the unit.

However, the record contains no evidence that titled charge nurses are actually rated on this

factor, or that a positive or negative rating in this category has some impact on the titled charge

nurses' terms and conditions of employment.

Like the Employer herein, the employer in Golden Crest Healthcare Center, 348 NLRB

No. 38 (September 29, 2006), argued that its charge nurses were held accountable for the

responsible direction of subordinate staff, based on a category in their performance appraisals

that ranked them in the direction of CNAs. However, as in the instant case, the Board noted that there was no evidence that these evaluations resulted in any action with respect to the charge nurses. "[T]he mere fact that charge nurses were rated on this factor does not establish that any adverse consequences could or would befall the charge nurses as a result of the rating. Thus, we find that the 'prospect of adverse consequences' for the charge nurses here is merely speculative and insufficient to establish accountability." *Id.*, slip op. at 7. Similarly, the Employer in the instant case presented no evidence that the titled charge nurses are held accountable for the direction of work. Accordingly, I find that the titled charge nurses do not responsibly, direct work within the meaning of Oakwood.

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Accordingly, I find that the titled charge nurses use independent judgment in assigning RNs to patients and are statutory supervisors. Accordingly, I shall exclude the titled charge nurses (evening/night charge nurses) from the bargaining unit found appropriate herein.

Rotating charge nurses

The Employer contends that the level III and IV rotating charge nurses exercise the same supervisory authority as the titled charge nurses, and should be excluded from the proposed bargaining unit. I find, however, that, unlike the titled charge nurses, that the Employer has failed to meet its burden in demonstrating that the rotating charge nurses are supervisors within the meaning of Section 2(1.1) of the Act.³² In so finding, I note that, unlike the titled charge nurses, the record reveals no evidence that the rotating charge nurses exercise any secondary indicia of supervisory status. In this regard, the record demonstrates that there is no separate job description or performance appraisal for rotating charge nurses and, as discussed elsewhere in this decision, the record contains no evidence that rotating charge nurses enjoy different wages or benefits when performing charge duties than the staff RNs. As an initial matter, I note that not all level III and IV RNs perform charge duties and the

Employer fails to identify with specificity which RNs it seeks to exclude on the basis of their ability to perform charge duties. As the party bearing the burden in the instant case, it is incumbent on the Employer to provide specific, detailed evidence that supports its argument that the rotating charge nurses are statutory supervisors. In order to meet its burden, the Employer must initially demonstrate that the rotating charge nurses spend a regular and substantial portion of their time performing supervisory functions. *Brown and Root, Inc.*, 314 NLRB 19, 21 (1994); *Gaines Electric Company*, 309 NLRB 1077, 1078 (1992); *Aladdin Hotel*, 270 NLRB 838 (1984).

32 I shall separately address the Employer's contention that the level III and IV RNs are statutory supervisors on other grounds.

61

In *Oakwood*, the Board declined to find certain rotating charge nurses to be statutory supervisors where the employer presented "only superficial evidence" regarding the regularity with which the rotating charge nurses served in the charge capacity. The Board found that "in the absence of a sufficient showing of regularity for assigning the 'rotating' charge nurses, we need not decide whether these RNs possess the 'rotating' charge duties for a 'substantial' part of their work time." 348 NLRB No. 37, slip op. at 13.

In the instant case, the Employer argues that approximately 74 level III and IV RNs should be excluded from the unit because they can and sometimes do perform charge duties. However, because the record fails to establish the regularity and frequency with which most of these level III and IV RNs perform charge duties, based on *Oakwood*, I need not consider

whether these individuals exercise supervisory indicia for that portion of their work time spent as rotating charge nurses.

However, the Employer has presented evidence that level III RNs Jill Towns, Kathy

Alejongarcia, Stephen Sommer, Kristine Sykes, Fern Stein, Hope Wootan, Wendy Bodenweber

and level IV RN Mary Priede perform charge duties on a regular basis.

Accordingly, I will

consider whether these individuals are statutory supervisors within the meaning of Section 2(11) of the Act.³³

The Employer argues that the rotating charge nurses are the individuals primarily responsible for adjusting staffing levels on the units. In support of these arguments, the

Employer proffers a great deal of evidence that the rotating charge nurses have the authority to

33 Although the Employer identified other individuals, such as level III RN

Kathleen Oldehoff, who sometimes

perform charge duties, it failed to provide any evidence as to the frequency or regularity with which these other

individuals perform charge duties. In the absence of such evidence, and in accordance with the Board's decision in

Oakwood, I shall not decide whether these individuals are supervisors within the meaning of Section 2(11) of the

Act.

62

call employees in or off from work, adjust work schedules, and authorize overtime. Although

the Employer provided several detailed examples of occasions when rotating charge nurses asked

RNs to stay late or to come in early, as noted earlier herein, the record contains unequivocal

evidence that the rotating charge nurses have no authority to require employees to adjust their

schedules. In fact, the record demonstrates that the Employer has a strictly enforced "no

mandation" policy, meaning that no employee can be required to work other than their regularly scheduled shift.

It is well established that the party seeking to establish supervisory authority must show

that the putative supervisor has the ability to *require* that a certain action be taken. Where, as

here, the putative supervisor has the authority only to *request* that a certain action be taken,

supervisory status has not been established. Golden Crest Healthcare, 348 NLRB No. 39, slip

op. at 4., citing Heritage Hall, E.P.I. Corp., 333 NLRB 458, 459 (2001) (LPNs found not to

exercise supervisory authority where they had no authority to require off-duty employees to fill a

particular shift). Accordingly, I find, contrary to the Employer, that the rotating charge nurses do

not exercise supervisory authority by adjusting staffing levels on the unit."

Regarding the Employer's assertion that the rotating charge nurses make effective recommendations regarding discipline and evaluations, I find that the record fails to demonstrate that the rotating charge nurses effectively recommend discipline or make effective recommendations regarding performance appraisals. I make this finding on the same basis that I found that the titled charge nurses do not possess these supervisory indicia, namely the absence of evidence demonstrating that the recommendations of either the titled or the rotating charge

34 The Employer asserts in its post-hearing brief that the charge nurses are the ultimate authority on staffing on their respective units and that they can transfer staff between units, and that the nursing supervisor's role is merely that of planning. I note, however, that this contention is contrary even to the testimony provided by the Employer's witnesses at the hearing.

63

nurses regarding discipline and performance appraisals affect the terms and conditions of employment of the employees that they purportedly evaluate. Likewise, I find that, like the titled charge nurses, the record fails to demonstrate that the rotating charge nurses responsibly direct staff within the meaning of Oakwood. To that end, I note that the record establishes no evidence that the rotating charge nurses are evaluated based on the direction of work to other employees or that they receive any benefit or incur any detriment as a result of their direction of work. On the contrary, level III RN Stephen Sommer,

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who rotates as charge nurse on 3 Spellman, testified that he has never been disciplined for an LPN's or CNA's failure to perform a task, and he is not evaluated on whether the CNAs and LPNs perform designated tasks. Accordingly, I find no evidence that the rotating charge nurses responsibly direct employees. See Lynwood Manor, 350 NLRB No. 44 (July 31, 2007), slip op. at 4 (no finding of responsible direction in the absence of any specific evidence that nurses may be disciplined, receive a poor performance rating or suffer any adverse consequences with

respect to their terms and conditions of employment due to a failure in a CNA's work performance).

Thus, the remaining issue in determining whether the rotating charge nurses are statutory

supervisors is whether these individuals have the authority to assign work within the meaning of

Oakwood. I find that, unlike the titled charge nurses, that the Employer has failed to meet its

burden in demonstrating that the rotating charge' nurses use independent judgment in assigning

work to RNs, LPNs and CNAs.

It is well established that the party seeking to exclude an individual from the proposed

bargaining unit has the burden of establishing that the individual is ineligible to vote. Ohio

Masonic Home, 295 NLRB 390 (1989). Conclusory testimony without supporting evidence does

64

not establish supervisory status. Sears Roebuck & Co., 304 NLRB 193 (1991).

I find that the record contains inconclusive and conflicting evidence with respect to the

manner in which Jill Towns, Kathy Alejongarcia, Stephen Sommer, and Khristine Sykes assign

patients to nurses when acting as charge nurses. In so finding, I note that while the Employer

presented essentially unrebutted testimony about the duties of the titled charge nurses, the sum of

the evidence contained in the record regarding the rotating charge nurses is highly contradictory.

It is well established that where the evidence is in conflict or is inconclusive on particular indicia

of supervisory authority, the Board will find that supervisory status has not been established.

Phelps Community Medical Center, 295 NLRB 486, 490 (1989).

Level III RN Jill Towns performs charge duties 3 SMC at least once a week.

When acting

as charge nurse, Towns normally carries a patient load. Nursing manager Drake testified' when

acting as charge, Towns makes patient assignments in the same manner as titled charge nurses

Tatar and Jones. Specifically, according to Drake, Towns factors in the acuity of the patients, the

experience levels of the nurses and stroke certifications.

However, level III float pool nurse Kaiser testified that when she works on 3 SMC, she

has witnessed nurses, unit clerks and unit coordinators assign beds to patients.

Kaiser testified

specifically that, at some point during the last year, clerk Brenda Malone asked for RNs to

volunteer to take admissions. Kaiser further testified that when she works on 3 SMC, patients

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are assigned to her based on geography. Although nursing manager Drake stated that patient

assignments are based on the skills, education and licensure of the RNs, Kaiser testified that she

has repeatedly been assigned stroke patients based on their location on the unit, even though she

is not certified to care for these patients.

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Level III RNs Kathy Alejongarcia and Stephen Sommer rotate as charge nurses on 3

Spellman. Director of surgical services Krasher testified that the rotating charge nurses on 3

Spellman exercise discretion in assigning patients to nurses, specifically factoring in the skill of

the nurse, the stress level of the nurse, and the acuities of the patient. According to Krasher, the

rotating charge nurses assign RNs to new admissions coming onto the unit, and can adjust

staffing based on changes in the unit, like emergencies or discharges', after discussion with the

. . nursmg supervisor.

Level III RN Sommer testified, however, that when he is acting in the charge nurse

capacity on 3 Spellman, he. assigns patients with the goal of equalizing the patient load among

the nurses, and when a new admission comes onto the floor, he assigns that patient to the RN

with the fewest patients. According to Sommer, although he does not factor in the skill of the

RNs when making assignments because he assumes all RNs can perform all duties necessary on

the unit, he does factor in patients that require a heavy level of care when making assignments.

Both Sommer and level III float RN Jennifer Kaiser, who floats to 3 Spellman, testified that on ~

Spellman, RNs' workloads are assigned to be fairly equal. Sommer testified that no one from

management has ever told him that he is a supervisor. Kaiser testified that she conveys any

problems she has directly to the nursing supervisor.

Nurse manager Keane testified that on the oncology unit, level III RN Khristine Sykes

decides which patients go to which nurse, based on the skill level of the staff member, when she

acts as charge nurse. Keane testified that Sykes normally takes leukemia patients for herself, or

assigns those patients to another nurse with the skill to care for them. Sykes has never been

disciplined based on staffing decisions. Level III float pool RN Jennifer Kaiser, however,

testified that staffing on the oncology unit is different than on other units based on the long-term

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nature of the patients and the goal of ensuring continuity of care. Essentially, according to

Kaiser, RNs select the patients they wish to care for and Kaiser, as the float nurse, takes the

overflow. Kaiser stated that on oncology, the patients are distributed equally among the RNs

whenever possible.

I find that the Employer has not met its burden in demonstrating that level III RNs Jill

Towns, Kathy Alejongarcia, Stephen Sommer and Khristine Sykes exercise independent

judgment in making patient assignments on their respective units. In so finding, I note that much

of the testimony provided by the Employer regarding RNs who rotate as charge nurses is vague

and conclusory. In this regard, I note that the Employer's witnesses provided a great deal of

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generalized testimony that all charge nurses consider patient acuity and nursing skills in

assigning patients, but provided very little detailed testimony about the manner in which the

rotating charge nurses made staffing decisions.

Level III RN Sommer, who rotates as a charge nurse, and level III float RN

Kaiser,

however, testified in significantly greater detail about the manner in which patient assignments

are made on the units. Specifically, Sommer testified that when making patient assignments, he

initially seeks to assign patients to the same nurses who cared for them the night before, and then

makes adjustments to equalize workloads. This testimony undermines a finding that the rotating charge nurses exercise independent judgment in making patient assignments. The Board has routinely noted that assignments made solely to equalize workloads are routine and do not require independent judgment. See *Golden Crest Healthcare*, 348 NLRB No. 39,fn. 9. To the extent that Sommer stated that he considers patient acuity, such testimony is insufficient to establish that Sommer exercises independent judgment in assigning patients to nurses. *Lynwood Manor*, 350 NLRB No. 44, slip op. at 2.

67

Kaiser testified that, with the exception of the oncology unit, her patient assignments are based on the location of the patients, with no regard to her skills or education. Kaiser further testified that on the oncology unit, the RNs make staffing decisions among themselves. Thus, I find, based on the contradictory evidence in the record regarding the assignment of patients by the rotating charge nurses on 3 SMC, 3 Spellman and the oncology unit, that the Employer has not met its burden in demonstrating by a preponderance of the evidence that Jill Towns, Kathy Alejongarcia, Stephen Sommer and Khristine Sykes utilize independent judgment within the meaning of *Oakwood* in assigning patients to nurses when serving as rotating charge nurses.

See, e.g., *Croft Metals*, 348 NLRB No. 38 (September 29,2006), slip op. at 5. Likewise, I find that the Employer has not met its burden in demonstrating that level III

RNs Fern Stein and Hope Wootan on the mental health unit, and level III RN Wendy

Bodenweber and level IV RN Mary Priede in endoscopy, exercise independent judgment in

making patient assignments when they are serving as rotating charge nurses.

Regarding Stein and Wootan, administrative director Chick testified that admissions are

assigned automatically to one of four patient groupings, based on the identity of the treating

physician. Although Chick testified that Stein and Wootan can decide to transfer patients from

one RN to another because of workload, personality conflicts, and safety or personal reasons, she

provided no testimony that either Stein or Wootan has ever done so. This vague testimony does not establish that Stein and Wootan exercise independent judgment.

In *Avante at Wilson*, 348 NLRB No. 71 (October 31, 2006), the Board found that the

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conclusory testimony of a unit manager that she was "familiar" with a disciplinary incident was

insufficient to establish supervisory status. As the Board noted, "the testimony is utterly lacking

in specificity" and noted that "she failed to particularize her testimony in any way." *Id.*, slip op.

68

at 2. Likewise, I find administrative director Chick's testimony to be equally conclusory,

particularly in the absence of any testimonial or documentary evidence in support thereof

anywhere in the record. Accordingly, I find that the Employer has not demonstrated by a

preponderance of the evidence that level III RNs Stein and Wootan utilize independent judgment

in assigning work within the meaning of *Oakwood*. See also *Loyalhanna Care Center*, 352

NLRB No. 105 (June 30, 2008), slip op. at 2 (where the Board found that the director of nurses'

generalized testimony regarding the assignment of staff to patients was "merely conclusory and

hence insufficient to establish independent judgment").

Similarly, I find no evidence that level III RN Wendy Bodenweber and level IV RN Mary

Priede, when serving as rotating charge nurses, make assignments in endoscopy that require the

use of independent judgment. Level III RN Wendy Bodenweber is charge nurse every

Wednesday, and level IV RN Mary Priede is charge nurse the remainder of the week. Although

administrative director Chick testified that Bodenweber and Priede can call staff in to work, as

noted above, they have no authority to require staff to report to work. Regarding patient

assignments, the record demonstrates that the RNs rotate through the various procedures at one

week intervals. Thus, the record contains no evidence that Bodenweber and Priede even make

patient assignments, much less utilize independent judgment in doing so.

Based on the above, I find that the Employer has not demonstrated by a preponderance of the evidence that Jill Towns, Kathy Alejongarcia, Stephen Sommer, Khristine Sykes, Fern Stein, Hope Wootan, Wendy Bodenweber and Mary Priede, when serving in the charge nurse capacity, are statutory supervisors within the meaning of Section 2(11) of the Act. Although not dispositive, I note that the record contains no evidence explaining why these individuals, some of whom the Employer asserts act in the charge nurse capacity 75

69

percent or more of their work time, are not in the evening/night charge nurse classification.

Likewise, the Employer provides no explanation as to why rotating charge nurses carry patient

loads while the titled charge nurses normally do not. Although the Employer urges that Level III

and IV RNs who rotate as charge nurses are supervisors, while level II RNs who rotate as charge

nurses are not, it provides no evidence demonstrating any distinction in the charge duties of the

level II RNs and the levels III and IV RNs. Finally, I note that the record fails to demonstrate

that these individuals possess even secondary indicia of supervisory status, such as a distinct job

title or increased pay,³⁵ or that any of the rotating charge nurses are ever the highest-ranking

individuals in the facility."

Level III and IV RNs

The Employer contends that, in addition to the ability to perform rotating charge duties as

discussed above, all level III and IV RNs are supervisors within the meaning of Section 2(11) of

the Act because they act as preceptors and direct the work of staff. I find that the Employer has

failed to meet its burden in demonstrating that all level III and IV RNs are supervisors based on

either their duties as preceptors, or the responsible direction of staff.

The Employer argues that level III and IV RNs effectively recommend the hire of new

nurses in their capacity as preceptors. The record demonstrates that precepting is voluntary, and

that level II, III and IV RNs can act as preceptors after taking a preceptor course offered by the

Employer. The Employer identified several individuals who act as preceptors, such as level III

35 As noted above, I decline to find that the rotating charge nurses receive \$1.00 more per hour, based on the

conflicting evidence in the record regarding this issue and the Employer's failure to produce documentary evidence

that would presumably have supported its position on this issue.

36 Although the Employer proffers in its brief that the charge nurses are the highest ranking individuals in their

respective units when on duty, the record demonstrates unequivocally that a nursing supervisor is always at the

facility during the evening/weekend shifts and is the highest-ranking individual in the hospital at those times. The

record further demonstrates that the various nurse managers, department directors and clinical coordinators are on

call 24 hours a day.

70

RNs Jill Towns, Fern Stein, Jennifer Tatar, and Kathy Alejongarcia. The Employer proffered

no evidence that Jill Towns is a "primary" preceptor, that Fern Stein has been a preceptor for Eve to

ten years, that Jennifer Tatar has precepted many RNs, and that Kathy Alejongarcia acts as a

preceptor, and Sommer testified that he has acted as a preceptor.

Although the Employer contends that all level III and IV RNs can act as preceptors, the

record does not disclose the identities of all RNs who choose to do so, nor does it disclose the

regularity or frequency with which RNs perform precepting duties. In the absence of such

evidence, I am unable to find that RNs are statutory supervisors based on the performance of

preceptor duties. See St. Francis Medical Center-West, 323 NLRB 1046 (1997) (sporadic

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exercise of supervisory duties, even where substantial, does not establish supervisory status).³

Even assuming arguendo that I need consider whether RNs are supervisors on the basis of

their performance as preceptors, I find nonetheless that the record contains no evidence that

preceptors effectively recommend employees for hire. Based on the arguments set forth in the

Employer's brief, it appears that the Employer contends that preceptors effect the retention of

orienteers, rather than the hire of new employees.

To the extent that preceptors give opinions to supervisors regarding an orientee's progress, I find no evidence that these opinions constitute effective recommendations.

In *St. Mary's Hospital, Inc.*, 220 NLRB 496 (1975), the Board considered whether certain

in-service trainers were supervisors within the meaning of the Act based on feedback the trainers

provided to management regarding trainees. In declining to find supervisory status, the Board

37In finding that the Employer has not met its burden on this issue, I note that the Employer failed to provide time

detail reports that could easily have quantified the time spent by each level III and IV in precepting duties. The

Employer's failure to produce documents, particularly in the face of an outstanding subpoena, warrants an inference

that these documents would not be favorable to the Employer's cause. *RCC*

Fabricators, Inc., 352 NLRB No. 88

(June 9, 2008).

71

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noted:

Their function is to teach new employees during a brief 2-week orientation period. In their teaching capacity, it is necessary for the instructors to evaluate the new employees and inform their superiors of the new employees' success or lack of success in orientation. The instructor may extend the orientation period of a new employee encountering problems. Nonetheless, we cannot conclude that the teaching function of the instructors automatically leads to a finding that the instructors promote or discharge employees or make effective recommendations regarding the job status of new employees

Id. at 498.

I find that the feedback provided to management by RNs acting as preceptors is part of

the teaching process, and does not convert RNs acting as preceptors into statutory supervisors. I

further note that, to the extent the Employer might argue that preceptors make effective

recommendations regarding orientee evaluations, I find no evidence that preceptors recommend

that any action be taken. Rather, the record demonstrates that, at most, the preceptor gives an

opinion as to the progress of the orientee. The Board has noted that oral or written reports that

bring performance issues to the employer's attention are, without more, merely reportorial.

Passavant Health Center, 284 NLRB 887, 890-891 (1987).

The Employer also argues that level III and IV nurses direct the work of staff. In the

hearing, the Employer contended that level III and IV RNs direct the work of staff via their

participation in councils that revise and create policies that are then implemented among the

staff.³⁸

The evidence in the record demonstrates that 30 to 40 percent of the

membership on

three hospital-wide councils consists of staff employees, including level II, III and IV RNs and

that these councils revise, review and create various policies. The record

demonstrates that all

³⁸ The Employer does not raise this argument in its post-hearing brief.

72

policies created or revised in these councils are reviewed by upper level

management such as the

human resource director or vice-president of patient care services, before they

are approved and

distributed to the units. The record contains no evidence that level III and IV RNs

approve or

effectuate policies. Thus, I find no evidence that level III and IV RNs direct the work of

employees by their participation in councils"

To the extent that the Employer argues that level III and IV RNs responsibly

direct staff

on the units, consistent with my findings regarding the titled and rotating charge nurses, I

likewise find that the record contains no evidence that level III and IV RNs are

held accountable

for the work performance of other employees within the meaning of Oakwood. In

so finding, I

note that level III RN Sommer testified that he has never been disciplined

regarding the work

performance of an LPN or CNA, and level III float RN Kaiser testified that she

was not held

accountable for a CNA's failure to take vital signs as directed by the treating

physician. As

noted throughout this decision, in the absence of evidence of actual

accountability, I find that the

record does not reflect that level III and IV RNs responsibly direct staff. Golden

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Healthcare Center, 348 NLRB No. 39 (September 29, 2006).

Accordingly, for the reasons noted herein, I find that the Employer has failed to

demonstrate by a preponderance of the evidence that level III and IV RNs are supervisors within the meaning of Section 2(11) of the Act.

Clinical Nurse Specialists

The Employer contends that clinical nurse specialists Marcy Truesdale and Arlene Cohen are supervisors because they discipline staff, act as supervisors when the unit managers are absent, make effective recommendations regarding performance appraisals, and make

39 The Employer does not allege that level III and IV RNs are managerial employees by their participation in councils, nor does the record demonstrate that they exercise managerial discretion in participating in these councils.

73

assignments and responsibly direct staff. I find that the record fails to demonstrate that

Truesdale and Cohen exercise any indicia of supervisory authority.

The evidence in the record regarding Truesdale consists solely of the following: she

works part-time between 3 SMC and the intensive care unit; teaches several courses; IS a

resource person for nurses that have questions about advanced practice and anything clinical; she

does not direct work or assign patients; and she on one occasion asked an RN for some

documents, unspecified in the record, regarding the RNs level III status. Such evidence is

insufficient to establish that Truesdale exercises any supervisory indicia.

Regarding clinical nurse specialist Cohen, the record demonstrates that she is in charge of

education for all staff on the oncology unit. Cohen's primary responsibilities are research and

staff education. Although Cohen does not perform patient care duties, the record demonstrates

that she works closely with nurses administering chemotherapy medications, creates training

opportunities for staff, and ensures that all staff are current on certifications and new advances in

medications and research.

Nurse manager Keane testified that Cohen directs staff by correcting improper standards

of care, and creating new policies and procedures that are implemented on the floor.⁴⁰ Keane

testified about an incident where Cohen assisted an RN who had improperly administered

medication, and then discussed the incident with Keane and the RN. According to Keane, Cohen created a new policy that was implemented on the unit as a result of this incident. The record demonstrates, however, that policies created by Cohen are reviewed for approval by other

40 The Employer does not assert that the clinical nurse specialists are managerial employees, nor do I find that the record would support such an assertion. The record contains no evidence that the clinical nurse specialists formulate management policies or are responsible for their implementation. Rather, the record demonstrates that the clinical nurse specialists make policy recommendations regarding patient care issues, and that all recommendations are subject to management review prior to approval and implementation. See, e.g., *George L. Mee Memorial Hospital*, 348 NLRB No. 15 (September 29, 2006) (Managerial employees formulate and effectuate management policies by expressing and making operative the decisions of their employer).

74 individuals. Although Cohen maintains education files for every RN on the unit and reviews nursing assessments to ensure that nurses are meeting the standards of care, the record contains no evidence that Cohen is held accountable for the staff's failure to meet these standards of care. With respect to discipline, I note that the record contains no evidence that Cohen disciplines employees. Although nurse manager Keane testified that Cohen participated in the termination of a CNA a few months prior, as noted by the Petitioner in its post-hearing brief, the record contains no evidence that Cohen was involved in the decision to terminate the employee, or that she even spoke at the termination meeting. Rather, the record demonstrates that Cohen's role was merely to act as a witness. Although Cohen reviews nursing assessments, this is insufficient to establish supervisory authority in the absence of evidence that the assessments result in discipline or other employment action. Keane testified in a conclusory fashion that Cohen supervises the unit when she and the clinical coordinator are not present. However, the record contains no evidence that Cohen has exercised any supervisory indicia in doing so. As noted throughout this decision, purely

conclusory evidence is not sufficient to establish supervisory status. The Board requires

evidence that the employee actually possesses the Section 2(11) authority at issue. Dean &

Deluca New York, Inc., 338 NLRB 1046 (2003).

Nurse manager Keane testified that she consults with Cohen when preparing performance

appraisals, and solicits her input regarding staff on the unit. Although Keane stated that she

relies on Cohen's recommendations, as with the other disputed classifications of RNs, the record

contains no evidence as to the impact, if any, that Cohen's input in performance appraisals has

on employees' terms and conditions of employment. Regarding the Employer's contention that

Cohen assigns and directs the work of employees, I find no evidence that she does so within the

75

meaning of Oakwood. In this regard, I note that the record contains no evidence that Cohen ever

assigns work to staff, and level III float RN Kaiser testified that she has never witnessed Cohen

assigning work on the oncology unit. Although Cohen creates training and educational

opportunities for staff, the record contains no evidence as to who makes the training assignments

to staff.

The Employer argues that Cohen responsibly directs staff by meeting with employees to

correct mistakes and discuss procedural methods. However, the record contains no evidence that

these meetings constitute direction of work. Rather, the record demonstrates that the meetings

are part of the education process. It is well established that the power to correct deficiencies of

staff does not establish supervisory status. See, e.g., Franklin Hospital Medical Center, 337

NLRB 826 (2002).

To the extent that the Employer argues that Cohen responsibly directs staff by creating

educational opportunities with patients, the record discloses no evidence that Cohen is held

accountable for the performance of staff on the oncology unit." For example, although Keane

testified that Cohen handled a problem with a chemotherapy treatment administered by an RN,

the record contains no evidence that Cohen was held accountable for the RN's error.

I find Cohen's role to be akin to the role of trainers discussed in *St. Mary's Hospital, Inc.*, 220 NLRB 496 (1975). Like the trainers in that case, the clinical nurse specialists herein are essentially teachers. Although the duties of the clinical nurse specialists include the ability to correct employees and report deficiencies to management, as noted above, these tasks are not indicia of supervisory authority.

41 The Employer argues in its post-hearing brief that Cohen is appraised on the performance of her educational responsibilities with respect to staff. However, this demonstrates only that Cohen is appraised based on her own job performance, not for the performance of other employees.

76

The record demonstrates that Cohen attends some management meetings. Although attendance at management meetings is evidence of supervisory status, this secondary indicia, in the absence of primary indicia, is insufficient to convert a rank-and-file employee into a supervisor. See, e.g., *Carlisle Engineered Products, Inc.*, 330 NLRB 1359 (2000). Although no party raises the issue of whether the clinical nurse specialists share a community of interest with other employees eligible for inclusion in the bargaining unit, I nonetheless note that the Board has found that clinical educators are appropriately included in acute care units of RNs. *Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205, 1212 (2003); citing *St. Mary's Hospital, Inc.* 220 NLRB 496 (1975); *Milwaukee Children's Hospital Assn.*, 255 NLRB 1009 (1981).

Based on the above, I find that the Employer has failed to demonstrate by a preponderance of the evidence that the clinical nurse specialists are supervisors, and I shall

include them in the unit found appropriate herein.

Accordingly, I find that the record fails to demonstrate that the petition is premature based on imminent and substantial changes to the proposed bargaining unit, or that any employees in the proposed bargaining unit are jointly employed by Nistel. I further conclude

that the Employer has met its burden in demonstrating that those individuals employed in the classification evening/night charge nurse are supervisors within the meaning of Section 2(11) of the Act, and I shall exclude them from the bargaining unit found appropriate here. I further find

that the Employer has failed to meet its burden in demonstrating that rotating charge nurses, level

III and IV RNs and clinical nurse specialists are statutory supervisors within the meaning of

Section 2(11) of the Act, and I include them in the bargaining unit found appropriate herein.

77

CONCLUSION

Accordingly, I find that the following employees constitute a unit appropriate for the

purposes of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time, regular part-time and per diem⁴² levels I, II, III and IV registered nurses, clinical nurse specialists, SWAT nurses, discharge nurses, care coordination nurses, staff educators, admission assessment registered nurses, and registered nurses on permit employed by the Employer, excluding office clerical employees, service and maintenance employees, technical employees, guards, all non-supervisory professional employees not working as registered nurses, and all managerial and supervisory employees, including the chief nursing officer, the program director of the rehabilitation unit, the director of surgical services, the administrative director of patient care services, the manager of infusion therapy, the director of care coordinators, denial management coordinators, infection control coordinators, quality assurance improvement (QAI) coordinators, risk management coordinator, the vice-president of patient care services, nurse managers, administrative directors, clinical coordinators, nursing supervisors and evening/night charge nurses.^f

There are approximately 269 employees in the bargaining unit found appropriate.

DIRECTION OF ELECTION

The National Labor Relations Board will conduct a secret ballot election among the

employees in the unit found appropriate above. The employees will vote whether or not they

wish to be represented for purposes of collective bargaining by New York State Nurses

Association. The date, time, and place of the election will be specified in the notice of election

⁴² In determining the status of per diem employees in the health care industry, "the Board has utilized various

eligibility formulae as guidelines to distinguish "regular" part-time employees from those whose job history with the employer is sufficiently sporadic that it is most accurately characterized as 'casual'." Sisters of Mercy Health Corporation, 298 NLRB 483 (1990). Consistent with the formula used by the Board in that case, I find eligible to vote those per diem employees who regularly averaged 4 hours or more of work per week during the calendar quarter (13 weeks) prior to the eligibility date. Id. at 483-484. See also Davison-Paxon Co., 185 NLRB 21, 24 (1970).

43 The exclusion for evening/night charge nurses pertains only to those three individuals who are referenced throughout this decision as titled charge nurses. This exclusion does not apply to any other staffRNs, levels I through IV, who may rotate as charge nurses.

78

that the Board's Regional Office will issue subsequent to this Decision.

A. Voting Eligibility

Eligible to vote in the election are those in the unit who were employed during the payroll

period ending immediately before the date of this Decision, including employees who did not

work during that period because they were ill, on vacation, or temporarily laid off.

Employees

engaged in any economic strike, who have retained their status as strikers and who have not been

permanently replaced are also eligible to vote. In addition, in an economic strike which

commenced less than 12 months before the election date, employees engaged in such strike who

have retained their status as strikers but who have been permanently replaced, as well as their

replacements are eligible to vote. Unit employees in the military services of the United States

may vote if they appear in person at the polls.

Ineligible to vote are (1) employees who have quit or been discharged for cause since the

designated payroll period; (2) striking employees who have been discharged for cause since the

strike began and who have not been rehired or reinstated before the election date; and (3)

employees who are engaged in an economic strike that began more than 12 months before the

election date and who have been permanently replaced.

B. Employer to Submit List of Eligible Voters

To ensure that all eligible voters may have the opportunity to be informed of the issues in

the exercise of their statutory right to vote, all parties to the election should have access to a list

of voters and their addresses, which may be used to communicate with them.

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Underwear, Inc., 156 NLRB 1236 (1966); NLRB v. Wyman-Gordon Company,

.394 U.S. 759

(1969).

79

Accordingly, it is hereby directed that within 7 days of the date of this Decision, the

Employer must submit to the Regional Office an election eligibility list, containing the full

names and addresses of all the eligible voters. North Macon Health Care Facility, 315 NLRB

359, 361 (1994). The list must be of sufficiently large type to be clearly legible. To speed both

preliminary checking and the voting process, the names on the list should be alphabetized

(overall or by department, etc.). This list may initially be used by me to assist in determining an

adequate showing of interest. I shall, in turn, make the list available to all parties to the election.

To be timely filed, the list must be received in the Regional Office on or before August 26,

2008. No extension of time to file this list will be granted except in extraordinary circumstances,

nor will the filing of a request for review affect the requirement to file this list.

Failure to

comply with this requirement will be grounds for setting aside the election whenever proper

objections are filed. The list may be submitted to the Regional Office by electronic filing

through the Agency's website www.nlr.gov,⁴⁴ by mail, by hand or courier delivery, or by

facsimile transmission at (716) 551-4972. The burden of establishing the timely filing and

receipt of the list will continue to be placed on the sending party.

Since the list will be made available to all parties to the election, please furnish a total of

three copies of the Est, unless the list is submitted by facsimile or e-mail, in which case no

copies need be submitted. If you have any questions, please contact the Regional Office.

44 To file the eligibility list electronically, go to www.nlr.gov and select the E-Gov tab. Then click on the E-Filing link on the menu. When the E-File page opens, go to the heading Regional, Subregional and Resident Offices and click on the "File Documents" button under that heading. A page then appears describing the E-Filing terms. At the bottom of this page, check the box next to the statement indicating that the user has read and accepts the E-Filing terms and click the "Accept" button. Then complete the filing form with information such as the case name and number, attach the document containing the eligibility list, and click the Submit Form button. Guidance for E-filing is contained in the attachment supplied with the Regional Office's initial correspondence on this matter and is also located under "E-Gov" on the Board's web site, www.nlr.gov.

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C. Notice of Posting Obligations

According to Section 103.20 of the Board's Rules and Regulations, the Employer must

post the Notices to Election provided by the Board in areas conspicuous to potential voters for at

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least 3 working days prior to 12:01 a.m. of the day of the election. Failure to follow the posting

requirement may result in additional litigation if proper objections to the election are filed.

Section 103.20(c) requires an employer to notify the Board at least 5 full working days prior to

12:01 a.m. of the day of the election if it has not received copies of the election notice. Club

Demonstration Services, 317 NLRB 349 (1995). Failure to do so estops employers from filing

objections based on non-posting of the election notice.

RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request

for review of this Decision may be filed with the National Labor Relations Board, addressed to

the Executive Secretary, 1099 14th Street, N.W., Washington, DC 20570-0001.

This request

must be received by the Board in Washington, DC by 5 p.m. EDT September 2, 2008. The

request may be filed electronically through the Agency's web site,

www.nlr.gov,⁴⁵ but may not


be filed by facsimile.

45 To file the request for review electronically, go to www.nlrb.gov and select the E-Gov tab. Then click on the EFiling link on the menu. When the E-File page opens, go to the heading Board/Office of the Executive Secretary and click on the "File Documents" button under that heading. A page then appears describing the E-Filing terms. At the bottom of this page, check the box next to the statement indicating that the user has read and accepts the EFiling terms and click the "Accept" button. Then complete the filing form with information such as the case name and number, attach the document containing the request for review, and click the Submit Form button. Guidance for E-filing is contained in the attachment supplied with the Regional Office's initial correspondence on this matter and is also located under "E-Gov" on the Board's web site, www.nlrb.gov.

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DATED at Buffalo, New York this 19th day of August, 2008.


PAUL J. MURPHY
Acting Regional Director
National Labor Relations Board, Region 3
Niagara Center Building – Suite 630
130 S. Elmwood Avenue
Buffalo, New York 14202